

**INFLUENCE OF HEALTH ORGANIZATION STRUCTURE AND  
PROCESS ON CITIZEN PARTICIPATION IN COMMUNITY HEALTH  
CENTRE DECISION-MAKING**

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## **Abstract**

The move toward primary health care renewal in Canada and in industrialized nations around the world is resulting in a fundamental change in the way health care is delivered. Citizen participation is one of the five pillars of primary health care- not just participation in decisions related to an individuals' health care treatment, but also from the larger perspective of decision-making that affects policy and structure within an organization. Health care organizations want to be responsive to the needs of their communities, and consumer-savvy citizens increasingly expect to play a part in the decision-making process of organizations.

The relationship between health care administrators, providers and citizens is sculpted by fundamental philosophies, values and processes. These include organizational culture, change process, social capital, citizen role definition and shared power or citizen empowerment. This research seeks to link the concepts and create an understanding of the dynamic and complex relationships which result in effective or ineffective citizen participation in decision-making within organizations. A theoretical framework was used which addresses these fundamental philosophies.

The object of this research is to explore the processes and structures of organizations that facilitate or hinder meaningful citizen participation. Community health centres (CHCs) have long been recognized in Canada and around the world as leaders in the facilitation of citizen participation, and this research reviews pertinent documents from fourteen CHCs across Canada. Some of the data collected from a national research project on community health centres is used. Through secondary analysis, the original results of the document audit are compared to the original results of a quantitative survey administered to volunteers, clients, health care professionals and board members at each site that collected information about community capacity, organizational capacity and outcomes.

Results of this thesis research are presented in a framework of community and organizational characteristics influencing the degree of public participation supported in the literature. The research presented in this thesis shows some relationship between supportive factors identified in the organization's documents and the degree of participation and satisfaction identified in the quantitative survey results. Possible reasons for this relationship are explored and recommendations are made based on a hierarchical model of participation, with greater citizen participation as the goal.

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Finally, I thank my friends, my family, and my partner, Garnett, for their emotional support, advice and belief in me especially when I found it hard to believe in myself.

### **Dedication**

I dedicate this thesis to my parents, David and Carole Thompson, whose belief in the value of continuing education provided great opportunities for their children and to whom I owe all things.

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## **Chapter 1**

### **Introduction to the Study Problem**

#### **1. INTRODUCTION TO STUDY PROBLEM**

The move toward primary health care renewal in Canada and in industrialized nations around the world is resulting in a fundamental change in the way health care is delivered. The greatest shift in philosophy for health care professionals, particularly those working in community settings, has been from a medical model to a primary health care model.<sup>1,2</sup> The importance and benefits of involving community members in health planning have been recognized since well before the declaration of Alma Ata in 1978. This landmark declaration is recognized as one of the earliest commitments to the development of primary health care as a model for health care delivery.<sup>3</sup>

The five principles of primary health care include health promotion, public participation, intersectoral and interdisciplinary collaboration, accessibility and appropriate technology.<sup>1</sup> Oakley and Kahssay assert the second principle, public (or citizen) participation, takes two forms: the first is personal involvement in the decision-making which will influence individual health care, and the second a more global perspective in which public participation leads to policy formation and influence on the structure of the organization.<sup>4</sup> This research focuses on the principle of citizen participation; specifically, organizational structures and processes associated with increased participation. In this research, the venue for analyzing various forms of citizen participation in health care decision-making is community health centres (CHCs) in Canada.

### **1.1. Purpose of Study**

The goal of including citizens in decision-making within an organization is multifaceted. Accountability and transparency of government and the health care system has become of significant concern to citizens, and participation in decision-making addresses this concern. Quality of decisions made with citizen input is debated by researchers, but it is agreed the potential for improved quality is there when a community has strong social capital.<sup>5</sup>

Public participation is given a great deal of attention in the drive for primary health care renewal. In reality, engaging citizens in health service planning can be fraught with challenges and a number of factors may be at play.

First, the organizational approach to citizen participation sets the 'tone' or context for participation that may be interpreted as paternalistic or tokenistic.<sup>6</sup>

Consequently, community members may react to such efforts with suspicion and mistrust. Compounding this sense of mistrust is the impression among citizens that the goal of increasing citizen participation is to delegate decision-making responsibility for unpopular decisions to the local level, thus shifting final accountability away from traditional decision-making bodies.<sup>7</sup>

Next, an inherent element of citizen participation is the concept of shared power. There may be the perception within the organization that public participation means a loss of power and control to the community, and thus efforts to support public participation may be only superficial.<sup>6</sup> Last, from the community's perspective, apathy and a sense of powerlessness are fatal to citizen ownership and empowerment, and impede participation.<sup>8</sup>

The concept of citizen participation has benefited from increasing importance in community health services in recent years. If health administrators remain true to

the principles of primary health care, public participation will be central to the development of appropriate and effective community services structures and programs. However, the question remains: how? What elements of the structure and function of health care organizations actually support public participation, and what elements hinder? How do we ensure the structures that support participation will overcome the barriers listed above and lead to community members participating in health services decision-making, and influence health policy making within the organization? Further, how do we ensure these structures and processes allow *all* citizens an opportunity to participate, not simply a subset with the education, time, authority and means?

### **1.2. Significance of Study**

As a result of the First Ministers Accord of 2000, federal funds have been dedicated to primary health care renewal in every province in the nation.<sup>2</sup> Part of the expectation of the funding is that regional health authorities will build in procedures for public participation to guide policymaking. In many provinces, these dollars are being used for the development of primary health care networks or community health centres. Health Authorities are responsible for the management of CHCs within their boundaries, and the extent of citizen participation within the site's administrative structure is dependent on the extent to which the Health Authority encourages and facilitates such participation.

As CHCs develop in Regional Health Authorities, it is of paramount importance to planners to understand the role the structure of the organization plays in optimizing citizen participation, in order to optimize public contributions to decisions. This involvement must go deeper than simply ensuring token representation on steering committees; it must include an understanding of the barriers and facilitators to participation and the degree of influence that citizens have on policy development within the organization.

While some authors argue that more research must be done to determine whether citizen participation actually results in better decisions in health care,<sup>9</sup> a necessary first step is a greater understanding of the power and decision sharing relationship between health care administrators, providers and citizens in health care services.

Data from a national research study, the Citizen Participation Partnership Project (CiPPP), was used in this research. Document content analysis data was compared to quantitative survey findings which identified the satisfaction citizens felt in the level of participation they experienced in that organization. The intent of this research was to determine if the conclusions reached in this phase support conclusions in the literature on citizen participation, and identify processes and structures that reflect best practices used in organizations in which citizen participation satisfaction is the greatest.

### **1.3. Current Research**

Internationally, examples can be found of citizen participation in health care organization decision-making mandated through legislation and formal policy. Flood and Archibald include the United Kingdom, Australia, Denmark, and the United States in their comparison to Canadian structures and processes for citizen participation.<sup>5</sup>

Current research literature focuses on citizen participation from two distinct perspectives: first, a formal role of citizen in making direct policy decisions, and second the citizen consulting or engaging in the decision-making process to improve the quality of decisions.<sup>5</sup> The original CiPPP research was undertaken because “the literature examining citizen participation in community-based health delivery organizational models has been rather sparse, and empirical evidence that

community boards empower citizens in relation to other stakeholders is not strong.<sup>10, p 5</sup>

Flood and Archibald outline a number of reasons to carry out further research on this issue. First, they attest a need to know the extent to which citizens are being engaged in meaningful decision-making processes. Next, a mechanism could be developed through further research to measure the degree to which citizen's values are reflected in the policy created. Finally, conflicting research evidence exists regarding whether increased citizen participation in health care planning actually leads to improvements in health care services in the domains that are important to citizens, such as quality, safety and accessibility.<sup>5</sup> If this is indeed the case, health care managers need evidence to initiate change related to those organizational structures and processes which enhance or inhibit citizen participation, in order to ensure a positive environment and facilitate meaningful citizen participation.

#### **1.4. Research Question**

The culture and values of an organization will dictate the extent to which citizens are enabled to participate in decision-making within the organization. These organizational values translate into structures and processes that either support or hinder citizen participation. Further, the structures will dictate *who* can participate—for example, those citizens with time, means, and authority or each citizen equally.

If citizen participation is valued by an organization, it will exhibit certain behaviours as supported by the processes and structures within the organization. These structures and processes are 'windows to the soul' of the organization—a statement of the culture and values placed on citizen participation. Examples of these structures and processes include an organization chart that shows volunteers

as part of the organizational structure, and a process to recruit volunteers. Staff job descriptions may include the expectation for community development work; and board membership is representative of the community served.

A subtle difference in the character of this issue is revealed when viewed through the lens of the various players in the equation. Client, volunteer, staff, board member and manager each have a unique set of expectations and needs to be addressed within the structures and processes of the organization. For example, a client may approach decision-making with the worldview of how the decision will affect his or her immediate health care expectations and needs. A staff member may consider the involvement of citizens in decision-making from the vantage point of workload management and program development. A manager may consider the issue from the perspective of budgetary implications and power sharing, and a board member from the point of view of greatest good for community served. In total, each player will have an effect on how the structures and processes develop within the organization, and in turn these structures and processes will effect the individual.

In this thesis research, I wanted to explore how organizations can best support citizen participation in organizational decision-making in order for that participation to influence policy development. The research question of this thesis applied the philosophical outlook both community development and organizational development to the design and data of the original CiPPP research. In sum, the question was: what organizational behaviours and structures enable or obstruct citizen participation in organizational decision-making in community health centres? In order to find the connection between organizational behaviours and structures that result in the enablement of citizen participation, I sought to find evidence of a connection between formal organizational documents and the

translation of organizational policies in the form of evidence of best practices within that organization.

### **1.5. Definitions**

Establishing common language is a challenge in the study of community participation in health care. Definitions of words used in this thesis proposal are found in a variety of literature resources; most references offer a slightly different interpretation of each word. Definitions of the words used in this research are found below.

**Best practice** is defined as a method or practice that has resulted in exceptional outcomes in a given situation and is considered by practitioners to be better than other known methods. It is assumed these ‘best practices’ could be applied to other situations to improve effectiveness and efficiency.<sup>11, 12</sup>

Another definition of ‘best practice is “a comprehensive, integrated and cooperative approach to the continuous improvement of all areas of health care delivery.”<sup>13</sup> This definition might also be called ‘effective practice’ or ‘better practice.’

**Capacity** can be conceptualized as the ability of a unit to create results.<sup>14</sup> These results can be positive or negative, and the ‘unit’ is an individual, an organization or a community. Capacity is often discussed in terms of skills or conditions such as participation, empowerment, and development required creating positive outcomes. These concepts are discussed later in this list of definitions.

- **Individual Capacity** is the ability that one person possesses to create positive results, and involves “elements of knowledge (e.g. understanding the determinants of health, knowing, and knowing when it is appropriate to use, a range of health promotion strategies), skills (e.g. community development



process skills, research, planning, project management and evaluation skills), and commitment (e.g. valuing community development principles, being oriented to holistic definition of health and health promotion).”<sup>15, p 18</sup>

- **Organizational Capacity** is best understood when considered from two perspectives. First, the foundation of organizational capacity is the capacity of the individuals within the organization. Therefore, organizational capacity, at its most base level, is “the knowledge, skills and commitments of the individuals of whom the organization is composed.”<sup>15, p 18</sup> Second, capacity is a characteristic of the organization as a distinct unit and is shaped by other forces within that unit. As an organization, “capacity entails elements of organizational culture and structure (e.g. leadership and communication practices, systems for participation and learning), policies (e.g. making health promotion {and community development} a priority, empowering employees to act), and resources (e.g. funding and human resources) in support of (community development) initiatives.”<sup>16, p 18</sup>
- **Community Capacity** As with organizational capacity, community capacity is comprised of the skills and abilities of the people who make up the community. Community capacity is also shaped by forces within the community as a unit, for example, community history and experience, geography, political environment or safety. Therefore, community capacity involves characteristics of communities that affect their ability to identify, mobilize, and address social and public health problems.<sup>17</sup>

**Capacity Building** is the cultivation and use of knowledge, skills, and resources that strengthen individuals or community groups enabling them to:

- participate and take action on behalf of themselves or their community
- participate in political, organizational and socioeconomic decisions and
- build structures, skills, and systems that will affect community and individual change.<sup>15, 17, 18, p 304</sup>

**Community** as a concept implies “interaction, identity, mutuality and shared values.”<sup>15, p 18</sup> Using these philosophic descriptions, community is described as:

- Community with boundaries consisting of a group of individuals living in a set area limited by time and space. This concept of community has political and geographic reality.
- Demographic community consisting of groups of individuals who share defined and mutually acknowledged characteristics (for example, age, race, social status, diagnosis of illness).
- Community as a set of subsystems and super systems that interact with the population. These systems include political and social entities such as physical environment, recreation, safety and transportation, communication, education, health and social services, economics, law and government, economy and religion.<sup>1, 19</sup>

While the concept of community seems simple, in reality communities are complex and heterogeneous. Practitioners must acknowledge that interaction among diverse groups of people can lead to conflict, or community ‘members’ may not wish to interact at all.<sup>18</sup>

**Community health centres (CHCs)** are “community-based health organizations that provide a range of primary health and social services through teams of health and social services professionals. CHCs are known for their emphasis on community care and citizen participation in decision-making.”<sup>15, p 1</sup>

**Culture** refers to a set of learned values, behaviours, and beliefs that are shared by a particular society or population, learned within a group, and passed from one ‘generation’ to the next.<sup>1, 20</sup> Culture is expressed through stories, language, rituals and ceremonies, and physical structures and space.<sup>21</sup>

- **Organizational culture:** organizational culture is unique due to the insular nature of organizations and the potential for rapid membership change. Survival and development of the organization depends on consistency, and new employees may be explicitly or implicitly encouraged to adopt behaviour patterns or styles that reflect the values of the organization. Organizational culture ensures values are shared by the members of the organization and persist over time even when group membership changes.<sup>20</sup>

**Determinants of health** are social, environmental and behavioural elements which interact and contribute to the state health in an individual or a community. The World Health Organization uses the determinants of health philosophy in its definition of health, which reads “health is a state of complete physical, mental, and social well-being and not merely the absence of disease and infirmity.”<sup>22, p 58</sup> The literature contains widely varying lists of health determinants.

Commonalities of the determinants of health include those elements within the control of the individual such as personal health practices and coping skills; those determinants which may be influenced by the individual but are also influenced by the external environment such as income and social status, social support networks, education, healthy child development and employment and working conditions; and those determinants which are outside of the individual’s immediate control such as physical environment, health services, genetics, culture and gender.<sup>23</sup>

From a medical model worldview, the determinants of health are defined as the “prepathological components that can be associated with the development of health problems. ... (Determinants incorporate) biological, psychological and social elements.”<sup>8, p 58</sup> Consequently, the medical model focuses primarily on personal behaviours and health services. Community development literature

concentrates on the socioeconomic determinants of health and consequently has a greater emphasis on global determinants.<sup>22</sup>

## **Development**

- **Community Development** is described in the literature in three ways: as a philosophy, as a process or practice, and as a finite project.
  - Community development as a philosophy is the lens or worldview a practitioner uses to make sense of the realities of community work and to order priorities. For example, the therapeutic or medical model approach to community development sees communities as dysfunctional due to problems rooted in health and social realities such as family breakdown, loss of traditional culture and values, or alcohol and drug abuse. The liberation model of community development sees communities as downtrodden by political and economic oppressors. Community members must move through the process of development by taking back power that is rightfully theirs.<sup>24</sup> The application of each of these worldviews would result in quite different priorities for practitioners, but the goals are essentially the same.
  - Community development as a process or practice is the application of the philosophy of community development in a practitioner's day to day work in order to strengthen and build healthy communities. It is an approach to supporting health and well being "whereby citizens organize and take action to resolve community problems, develop citizen leaders, mobilize community resources and achieve a more democratic method of planning and decision-making in local communities."<sup>1, p 261</sup> The process is integrated with and complementary to health service delivery.<sup>25</sup>
  - Community development as a project is evident when practitioners use community development as a method to co-opt community members to participate with an externally developed project. Community

development is tied to the finite boundaries of the project. This narrow view of community development may not be viewed as ‘true’ community development.

Regardless of the motivation of community development or the way in which it is written in the literature, the goals and expected outcomes are consistent. They include improvement in the community, planned change processes, and empowerment of community members.<sup>1</sup>

- **Organizational development** is a planned, system wide response to change; a complex educational strategy that uses a variety of ways of knowing (economic, sociocultural, psychological and anthropologic) intended to change the beliefs, attitudes, values and structure of organizations in order to improve organizational effectiveness.<sup>21, 26</sup>

**Empowerment** can be described in terms of an action and as a process. As an action, empowerment is the “endowment or enabling of clients with the authority and strength to effect decisions, behaviours, and interventions.”<sup>19, p 328</sup>

As a process, empowerment is “a social action process that promotes participation of people, organizations, and communities towards the goals of increased individual and community control, political efficacy, improved quality of community life, and social justice”<sup>27</sup>. The difference between these two philosophies is the locus of power implied. Empowerment as an action suggests power is ‘given’ by one group to a subjugated group. Empowerment as a process suggests a more active role taken by the group being empowered.

**Organizations** are formal structures in which people work interdependently through patterned behaviours. Organizations are social and political entities through which resources are allocated to accomplish a set of goals.<sup>15, 21</sup>

**Outcomes:** “What is achieved, an improvement usually in health but also in attitudes, knowledge and behaviour conducive to future health.”<sup>15, p 19</sup>

**Participation** The concept of participation is not easily defined. Oakley and Kahssay identify two broad interpretations of participation, which represent distinct purposes for public participation:

Participation as a means: an organization ensures cooperation with externally developed programs using collaboration with citizens as the vehicle.

Participation as an end: participation is the goal in itself, such that power is transferred and empowerment of the participant occurs. The participant acquires skills, knowledge and experience to assume responsibility for outcomes.<sup>4</sup>

**Citizen participation:** the original CiPPP research references a definition of citizen participation by Spiegel that reads “the process(es) and (structures) through which citizens are meaningfully linked to programs/services.”<sup>15, p 18</sup>

Citizen participation has a wide variety of goals and outcomes, including improved community health outcomes, long-term maintenance of programs, and feelings of personal and political efficacy.<sup>19</sup>

- **Community Participation** As defined by the World Health Organization: “A process by which people are enabled to become actively and genuinely involved in defining the issues of concern to them, in making decisions about factors that affect their lives, in formulating and implementing policies, in planning, developing and delivering services and in taking action to achieve change.”<sup>15, p 18</sup> Community participation encompasses a range of activities from information sharing and pursuing participant feedback, to joint planning and organizing for health at the local level. Community participation is a two-way process that can be performed by local citizens, communities and a variety of organizations.<sup>15</sup>

**Participatory research** is defined by Frankish as “systematic inquiry, with the collaboration of those affected by the issue being studied, for purposes of education and taking action of effecting social change.”<sup>28, p 4</sup> Part of the objective of participatory research is to build capacity among the research ‘subjects,’ and the creation of a sustainable resource intended to stay in the community.<sup>29</sup>

**Power** is defined as “the faculty or capacity to act, the strength and potency to accomplish something. It is the vital energy to make choices and decisions. It also includes the capacity to overcome deeply embedded habits and to cultivate higher, more effective ones.”<sup>30, p 109</sup>

Power comes from various sources:<sup>19</sup>

- 1. Coercive power:** using force to gain compliance; compliance is the result of fear.
- 2. Reward power:** involves providing something for compliance
- 3. Expert power:** emanates from special knowledge or skills
- 4. Legitimate power:** the result of position or title
- 5. Referent power:** results from the identification with one believed to hold position of power, and
- 6. Information power:** the use of knowledge held by one and not another.

**Primary health care** is a philosophy of health care and not a method of service delivery. The World Health Organization Declaration of Alma Ata defined primary health care as:

Essential health care based on practical, scientifically sound, and socially acceptable methods and technology made universally accessible to individuals and families in the community by means acceptable to them and at a cost that the community and the country can afford to maintain at every stage of their development in a spirit of self-reliance and self-determination. It forms an integral part of both the country’s health system of which it is the central function and the main focus of the overall social and economic development of the community. It is the first level of contact of individuals, the family and the community with

the national health system, bringing health care as close as possible to where people live and work and constitutes the first element of a continuing health care process.<sup>31, p 10</sup>

The World Health Organization definition of primary health care was formally recognized by each CHC participating in the original CiPPP research process.

**Processes:** the original CiPPP research quotes Donabedian in the definition of processes, which reads “what is done in caring for patients.”<sup>15, p 19</sup>

- **Organization processes** are “assets that improve ... performance and provide a basis for cumulative, long-term benefits to the organization.”<sup>32</sup>

**Social capital** is the measure of a community’s ability to access resources and use them knowledgeably and effectively.<sup>17</sup> Social capital is often expressed in terms of social wellness, competence and empowerment, as well as the knowledge and skills of citizens.<sup>17</sup> Social capital requires community commitment, communication and facilitation skills, public participation, and the ability to manage change.<sup>25</sup>

**Structure** A definition by Donabedian was used in the original CiPPP research to define structure, and reads “the physical, organizational and other characteristics of the system that provides care and its environment.”<sup>15, p 19</sup>

- **Organizational Structures** are described by Jones in the original CiPPP research as “the formal system of task and authority relationships that an organization establishes to control its activities. Different structures give rise to different cultures.”<sup>15, p 19</sup> Three key components of organization structure are:
  1. Organization structure designates formal working relationships, including the number of levels in the hierarchy and the span of control of managers and supervisors.



2. Organization structure identifies the grouping together of individuals into departments and the grouping of departments in the total organization.
3. Organization structure includes the design of systems to ensure effective communication, coordination, and integration of efforts across departments.<sup>15, p 19</sup>

The first two elements represent the organization framework. For example, these components would be found in an organizational chart. The third component “pertains to the pattern of interactions among organizational employees.”<sup>15, p 19</sup>

### **1.6. Summary**

The goal of citizen participation in organization decision-making is multifaceted. Accountability, transparency, and quality of service are a few of the issues of concern to consumers of health care services, and may be addressed through citizen participation in organization decision-making.

The intent of this research was to attempt to identify those structures and processes of organizations that support or hinder citizen participation. Structures and processes of organizations were examined using a model which places all within the context of organizational culture, change process, social capital, citizen role definition and shared power or citizen empowerment.

## **Chapter 2**

### **Review of the Related Literature**

#### **2. REVIEW OF THE RELATED LITERATURE**

Several fundamental values fuel the curiosity of researchers regarding citizen participation in health care decision-making. Mutual respect, quality of services, and a belief in the intrinsic value of community and experiential knowledge are but a few. The literature reveals that research and development in the fields of citizen participation and organization development centres on a number of key topics.

My literature review focused on community development literature and organizational development literature. My goal for the literature review was to synthesize existing philosophies and approaches to community development research within an organizational context, specifically health care organizations. In this chapter, the historical context of citizen participation and relevant literature is reviewed in relation to organization development and the citizen's role within organizations. Key concepts are discussed and connections between these concepts established. Conceptual models are chosen from the literature and established as the map for this thesis research.

#### **2.1. From 'Patient' to Partner: The Changing Context of Health Care and Citizen Participation**

Reflecting on the culture and traditions of western medicine provides insight into the position that citizens are expected to assume within western health care culture. Even the word 'patient' denotes a passive recipient and reinforces a hierarchy in which the citizen remains an outsider and cannot be a true partner.

Organizational language, as unique as any dialect, is used among members of the health care culture and can be mysterious and baffling to the citizen.

Organizational customs and rituals that are familiar and comfortable for members can be frightening and disempowering to citizens. Clearly this environment does not nurture meaningful participation and empowerment for citizens.

Citizen participation has long been recognized as an important factor to effective health care decision-making.<sup>33, 34</sup> The movement toward increasing citizen participation has a grassroots origin. The public demand for citizen participation has been influenced by several environmental conditions. First, the consumer movement has resulted in an increasingly savvy citizen who takes a growing interest in how tax dollars are spent and how health care is delivered. Second, an awareness of equity issues stemming from the feminist movement has resulted in changes to address “lack of information, lack of respect, lack of participation in the decision-making process, and lack of access to appropriate services.”<sup>34, p 4</sup> Third, the ‘baby-boomer’ generation brings “expectations of self-fulfillment, a strong scepticism, and a willingness to challenge and change institutions.”<sup>34, p 4</sup> Member of this generation are significant potential consumers of health care given the volume of the group. Finally, citizens have a growing dissatisfaction and distrust for institutions, and citizen participation may be a way for citizens to increase knowledge and control over the events within health care organizations.<sup>34</sup>

Economic trends and national health reform in the 1990’s were also a catalyst to the increased involvement of citizens in health decision-making. Health care administrative structures and service delivery models were reconfigured throughout the nation during this decade in order to shift emphasis from institutions to a community focus. At the same time, the role of the citizen in health care decision-making was enhanced.<sup>35</sup> The agenda driving this change was a combination of fiscal restraint and a belief in the value of citizen participation in

health care decision-making. Continued vigilance is required to ensure the value of citizen participation is not lost as governments and decision-makers change.

## **2.2. Current Knowledge of Citizen Participation: Research Evidence and Conclusions**

A number of case studies were found in the search for existing work.<sup>36-38</sup> This literature reveals a focus on two things: first, the evaluation of the effect of citizen participation on health outcomes, and second, on the process of participation itself. This review revealed a majority of the research considered citizen participation at the level of information seeking and sharing, well down on the participatory ladder described by Arnstein (discussed below). Further, only a few indirect references showed evidence of an examination of the structures and processes of an organization and how those structures enabled or hindered citizen participation.<sup>39, 40</sup>

Two important tools helpful in the research for this thesis included the work done for the Health Canada *Policy Toolkit for Public Involvement in Decision Making*<sup>39</sup> and *Improving Health Services Through Consumer Participation: A Resource Guide for Organizations*.<sup>40</sup> Each body of work expands on the models presented in the sections to follow.

## **2.3. Models of Participation**

This research is based within a theoretical framework of citizen participation to ascertain the level and type of participation that leads to optimal effectiveness in decision-making within an organization.

The concepts of this study are explored from the perspectives of community development and organizational development. Exploring interactions between citizens and organizations requires the application of each of these perspectives in

order to gain a full understanding of citizen participation in health care decision-making. Citizen participation is fundamental to community development, and organizational capacity must be such that citizens are empowered to participate.<sup>25</sup>

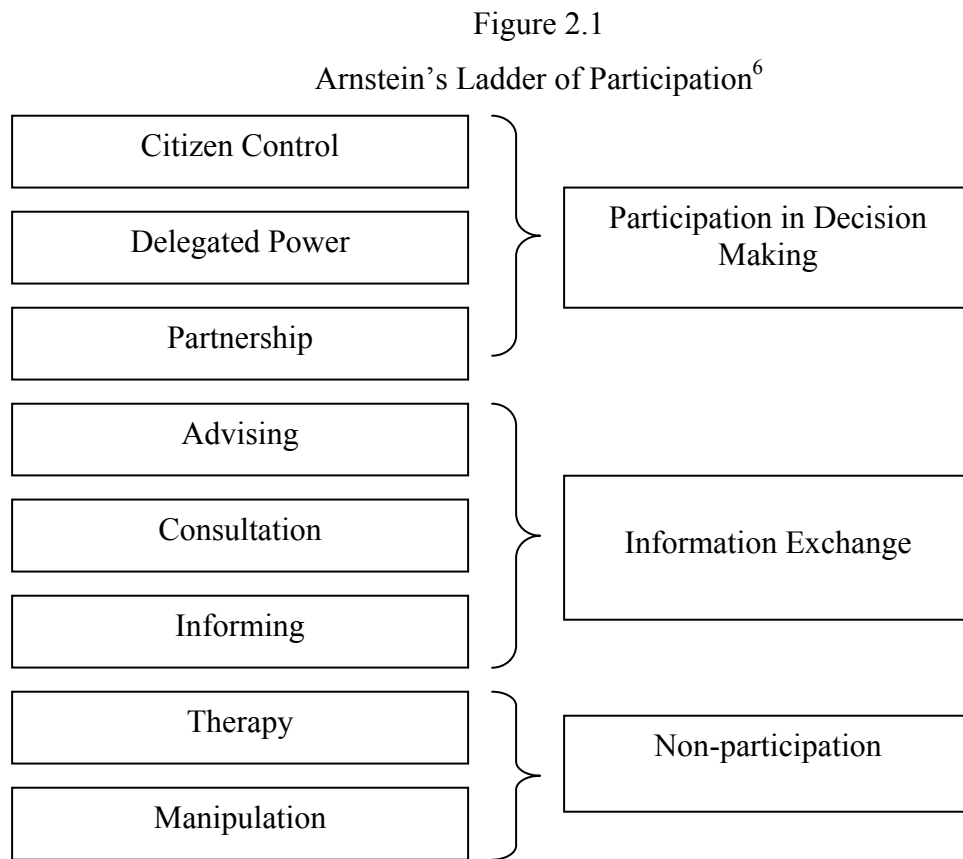
In Chapter 1, a definition of citizen and community participation was introduced. In this definition, participation was described as a process by which citizens are meaningfully linked to the programs they require. Participation was introduced as being either a means to an end where citizen participation would lead to a desired outcome, or an end in itself where participation was the goal.

Participation presents a unique set of issues when considering citizen participation in health care decision-making, particularly when considered from the distinct perspectives of individual participation, community participation, organizational participation and societal participation. ‘Participation’ means different things to different stakeholders, and this lack of clarity can lead to conflicting expectations between health professionals, citizens, organizations and communities. In this thesis, participation is considered from the perspective of 1) individuals and communities and 2) organizations.

### **2.3.1. Ladder of Participation**

Citizens bring distinct roles to the table when participating in health care decision-making. A number of frameworks exist that explore the conceptual basis of citizen participation within organizations, most of which illustrate the fact that citizen participation in health care decision-making follows a pattern of distinct gradations.<sup>9</sup> These gradations start with health organizations simply sharing information with citizens, and progress ultimately to complete citizen control of decision-making within the organization.

Throughout the literature, Arnstein's Ladder of Participation figures large in the different iterations of the levels of participation.<sup>6, 24, 34, 37, 38, 41, 42</sup> This model is based on a power and capacity gradient increasingly shared by the organization and by citizens. Wiebe et al. describe the eight levels of Arnstein's ladder, as shown in Figure 2.1 below.<sup>6</sup>



Wiebe et al. describe the eight rungs of the ladder in terms of their level of facilitation of participation.<sup>6</sup> The bottom two rungs, manipulation and therapy, represent those methods which do not facilitate citizen participation. Manipulation may be present when the support of citizens is conscripted by placing them on advisory boards or committees. Therapy is participation methods which are designed to adjust the values and attitudes of citizens to more closely reflect those of the organization.<sup>6</sup>

The next three rungs of the ladder, informing, consultation and advising, represent increasing participatory methods. These rungs are called ‘information exchange’ since true citizen ownership and control is not yet present. The predominant element of these three rungs is the flow of information from the organization to the citizen and back.<sup>6</sup>

The top three rungs of the ladder are those which represent true citizen participation and control. In these three rungs, power is redistributed and shared increasingly as the levels increase. Citizen control, the highest rung of the ladder, represents optimal participation where citizens have “obtained the right to govern a program or institution, to be in full charge of policy and managerial aspects, and to be able to negotiate the conditions under which others may change them.”<sup>6, p 165</sup>

While the Ladder of Participation is a useful tool in describing the levels of citizen participation in health care decision-making, it has a number of limitations as discussed by Kroutil and Eng. First, the model assumes communities and project participants are homogeneous in their participation within health system doctrine. In reality, communities and participants are diverse and their individual participation in, and reactions to, the health care decision-making process will be unique. Second, power is the only factor considered in the participatory dynamic between citizen participants and organizations, when in reality a number of elements influence the relationship such as social capital, education of professionals and characteristics of the organization. Finally, Kroutil and Eng maintain the model was designed to illustrate programs in which citizens and professionals share power on formal boards, therefore the model is best applied in situations where policy exists for citizen participation.<sup>38</sup>

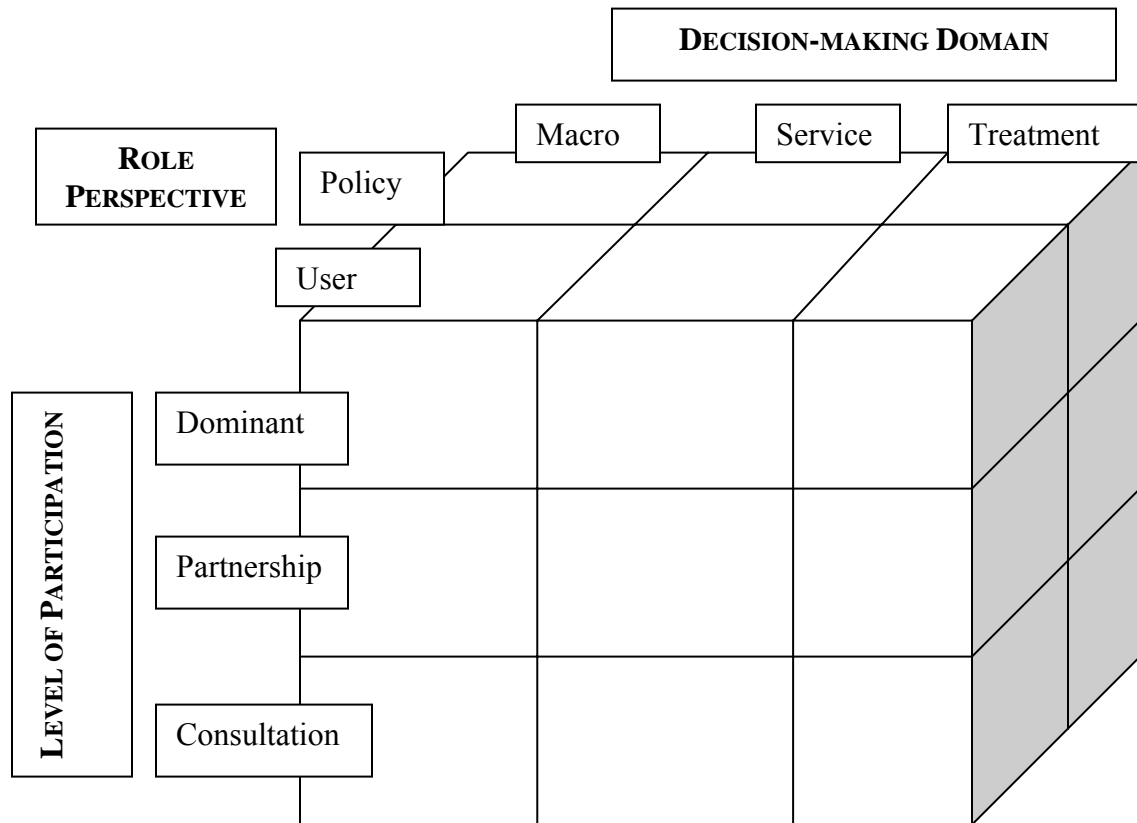
### **2.3.2. Participation Matrix**

The model selected to describe citizen participation and health care decision-making in this research is that of Charles and DeMaio.<sup>9</sup> This framework is a three-dimensional matrix which captures the complexity of roles that citizens bring to their responsibility as a citizen participant on health care decision-making bodies.

While the Ladder of Participation model shows participation as a linear continuum, the Participation Matrix model explores the various factors of the participation experience and participation itself becomes multifaceted. The matrix model allows the application of the continuum of participation taking into consideration the context of the participation. This matrix becomes important at the conclusion of this thesis where recommendations based on the findings of this research are made within the context of the matrix.



Figure 2.2  
Dimensions of (citizen) participation in health care decision-making.<sup>9, p 891</sup>



The first factor of the model is the role perspectives that citizens inherently bring to their responsibility as participants in decision-making. These perspectives include user of health services and public policy maker. The judgments and value systems an individual brings to a decision will vary depending from which of these two perspectives a citizen is considering a decision. The worldview will certainly be different if the citizen participant is considering the decision from the perspective of how this decision may affect him or her as a consumer of health care, or if he or she considers the decision from the perspective of the greater good for a community or society.

The second factor of this model is the decision-making domain that citizens bring to the participant role, which include macro, service and treatment domains. The macro domain relates to policy decisions undertaken that may influence the population on a broader scale, such as public policy made by provincial or federal governments. The service domain relates to the decisions an individual might be asked to make when considering distribution of health resources within a defined geographic area. The treatment domain relates to the decision-making in which an individual would be involved when faced with options about personal health care.<sup>9</sup>

The final element of the model developed by Charles and DeMaio is level of participation, or the “extent to which citizens have control over the decision-making process.”<sup>9, p 893</sup> This element is essentially the Ladder of Participation described by Arnstein and is the foundation of this model, since it is “key to defining what is meant by participation and the processes established to structure it.”<sup>9, p 893</sup> In this model, several levels of participation found in other ladder models have been collapsed into three: consultation at the lowest level of participation, partnership, and dominant as the most advanced level of participation. The authors argue that information is not a legitimate level of decision-making, since by definition there is no participation in decision-making when citizens are simply receiving information. Therefore, the model begins with consultation. As in other ladder models, the increasing levels of participation represent increased power sharing and access to resources.

Practical application of the matrix shows how the factors of ‘decision-making domain’ and ‘role perspective’ interact with the factor of ‘level of participation’ to describe the many possible combinations of citizen roles in decision-making within health organizations. Combining the two factors of decision-making

domain and role perspective yields eighteen possible decision-making cells; within which the level of citizen participation can range from lowest to highest.<sup>9</sup>

## **2.4. Factors Influencing Citizen Participation in Health Care Decision-Making**

### **2.4.1. Citizen and Community Participation**

‘Citizen’ and ‘community’ are closely linked entities; so close it is impossible to consider activities and processes of one without thinking of implications for the other. Most aspects of individual citizen participation also apply on a larger scale to the concept of community participation; like thinking of a hand as part of an arm and ultimately part of a human being.

In Chapter One, the literature discussing aspects of individual citizen participation was introduced. Participation in health care decision-making by citizens and communities is discussed in this section, understanding that communities are the larger organism composed of individual citizens.

#### **2.4.1.1. Community as a Concept**

“Community is a concept based on the notion that society cannot exist and progress without a set of mutual relationships expressing the obligations of individuals to each other and to the groups of which they are a part.”<sup>43, p 351</sup> While this description seems formal and detached, it sets the context for a discussion on the importance of understanding community in order to understand the dynamics of community development and the influence of community development on citizen participation in health care decision-making.

In the literature there exists a plethora of definitions and descriptions of community. Citrin’s description of community above provides further insight

when considering the three ways to conceptualize community: as a geographic reality limited by boundaries, time and space; as a demography consisting of a group of individuals sharing characteristics that persist across time and space; and as an organic system that “interacts with the community population to establish a dynamic balance.”<sup>19</sup>, pp 26-27

#### **2.4.1.2.Reasons For Participation**

The literature provides significant support for citizen participation in health care decision-making and elaborates on the reasons for participation, advantages and disadvantages, as well as benefits to individuals, communities, organizations and societies.

In recent years, the philosophy of primary health care has benefited from increased attention and commitment on behalf of policy makers and government. The driving force behind this commitment to primary health care is the recognition of the importance of sustainability of services and an upstream approach to health care through the determinants of health. This approach focuses on root causes of illness, such as poverty, housing, and education; and not only on the illness itself. The link between sustainability and root causes of illness is the belief that an investment in illness prevention and health promotion will save untold costs to the health system into the future. The link between this concept and citizens is the belief that only citizens have the knowledge of the unique determinants of health that affect them and, subsequently, these same individuals have a crucial role to play in finding solutions.<sup>4</sup> Further, citizens have a right to have input on “how ... services should be delivered, the form they should take, and the settings in which they should be provided.”<sup>41</sup>, p 1474

Therefore, citizen participation is a fundamental principle of primary health care.

A central concept in this thesis is the dynamic relationship between categories of citizens, including the general public, administrators and health providers, and how this dynamic influences decision-making within organizations. Many scholarly articles can be found which support citizen participation, but there is little research focused on the relationship between citizen participation in health care planning and organizational structure.<sup>9, 44</sup> Specifically, Church suggests researchers need to focus on “what motivates citizens to participate, the mechanisms and strategies employed to enhance citizen participation, (and) the impact of participation on the goals and outputs of the organization.”<sup>10, pp 2-3</sup>

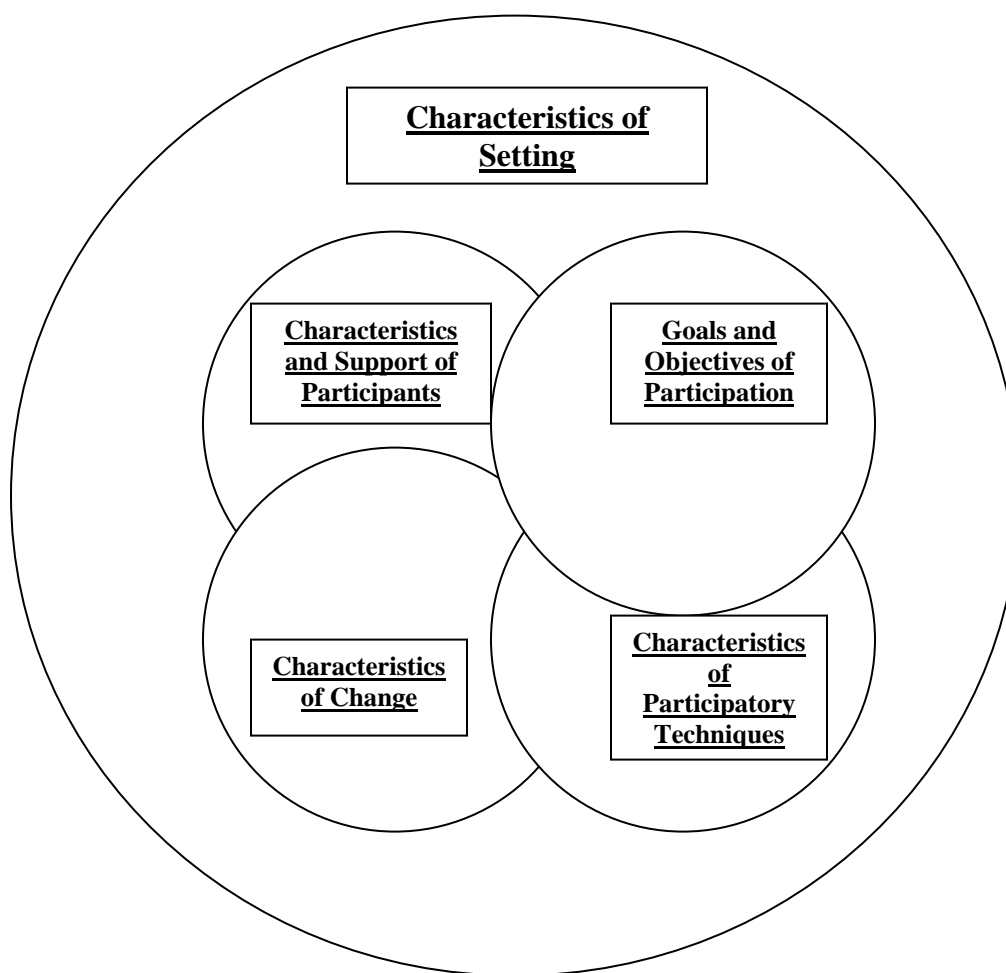
#### **2.4.2. Factors Influencing or Influenced By Citizen Participation: A Conceptual Model**

The matrix developed by Charles and deMaio, discussed earlier in this chapter, explains the complex nature of citizen participation in health care decision-making. Participation is not linear, as might be assumed from the ladder of participation concept. Rather, the Charles and deMaio matrix suggests participation at the macro, service and treatment levels is complex and influenced by a number of individual, societal and organizational factors. In the following sections, these individual, societal and organizational factors are discussed within the context of the Wiebe et. al conceptual model, drawing from evidence in the literature.

In their conceptual model of public participation, Wiebe et al. consider Arnstein’s Ladder of Participation in conjunction with a model of influencing factors to discuss the degree of public participation achieved in health care decision-making. They argue that, in organizations, participation is filtered through a lens of “social, political, cultural, economic and physical characteristics”<sup>6, p 162</sup> and, therefore, the degree of citizen participation must be considered in terms of five influencing factors within the organization: characteristics of setting,

characteristics of change, goals of public participation, characteristics and support of participants, and characteristics of participatory techniques. In this thesis, the Wiebe et al. model is used as a conceptual map to explore the elements of citizen participation and describe the forces affecting or affected by participation.

Figure 2.3  
Factors Influencing Degree of Public Participation<sup>6, p 163</sup>



#### **2.4.2.1.Characteristics of Setting**

The encompassing factor of this model is ‘characteristics of setting,’ and represents the context within which citizens participate in health care decision-making. Wiebe et al. describe a number of elements that compose characteristics

of setting, including community support, supportive organizational culture, developmental stage of the organization, and skill of participants at working together. These general characteristics are repeated in other literature.<sup>5, 17, 25, 37</sup>

Because the literature contained a great deal of information on characteristics of setting, I felt it was necessary to develop sub-categories within characteristics of setting in order to fully describe the factors that influence citizen participation and manage them within my conceptual map. Using the general characteristics repeated in the literature, I developed the following categories to further describe characteristics of setting for organizations and communities: 1) community/organizational capacity, 2) power, 3) social capital, 4) development and behaviour, and 5) culture.

The context of participation in health care decision-making has been described as a political and social phenomenon<sup>41</sup> and is fuelled by issues of power, public loss of faith in the institution of health care, and belief in the intrinsic value of citizen participation. The literature reveals other important elements related to characteristics of setting and context of participation such as community capacity, social capital and culture.<sup>5, 17, 25, 45</sup>

In this discussion of the elements of the Wiebe et al. model, I discuss the model from the perspective of the community first, then repeat the discussion from the perspective of organizations.

#### **2.4.2.1.1. Community Development and Capacity**

Community development and community capacity are closely linked concepts. Community development is described in the literature as a planned holistic approach to positively act on and build the skills of people and the structures and systems of communities. This strengthens a community's ability to address its

unique determinants of health through defining objectives, planning, managing projects, and taking part in partnerships.<sup>25, 37</sup> Community development is not ‘owned’ by the health care sector. By definition, all agencies with connection to a community must participate in community processes for community development to take place. Community development can be a conscious undertaking by any community group or an unintentional positive side effect of other development efforts.

A number of dimensions are used to describe community capacity, including “participation and leadership, skills, resources, social and interorganizational networks, sense of community, understanding of community history, community power, community values, and critical reflection.”<sup>17, p 260</sup> Positive or negative community capacity exists without community development efforts, and community development work is often undertaken with the primary intention of building positive community capacity. Like citizen participation, community capacity is argued in the literature as both a process and an outcome.<sup>17, 45</sup>

Goodman points out that community capacity is not static; communities can gain or lose capacity and capacity building is an important factor in community development.<sup>17</sup> Labonte explains that capacity building is begun when programs “improve community participation, develop local leadership, ... enhance (community members’ problem solving capacity), improve community resource mobilization, strengthen community links to other organizations and people, create an equitable relationship with outside agents, (and) increase community control over program management.”<sup>46, p 79</sup>

#### **2.4.2.1.2. Social Capital**

Social capital, like any kind of capital, is a type of ‘wealth’ that a community possesses. This is closely related to and perhaps even an outcome of community capacity, often expressed in terms of social wellness, competence and



empowerment, as well as the knowledge and skills of citizens.<sup>17</sup> Community commitment, communication and facilitation skills, public participation, and management of change by the citizens of the community contribute to building social capital.<sup>25</sup>

Evidence shows that where communities have stronger social networks and effective community capacity, citizen participation is evident and more likely to be meaningful and effective.<sup>5, 17, 25, 41</sup> Existing and effective community groups are more likely to be approached by an external organization in order for that organization to gain access to a community and attract citizen participants. However, this may contribute to the marginalization of certain populations because communities with pre-existing social capital may be invited to participate more readily than communities where organizations do not have an easy entry point. The easy availability of certain groups to organizations may result in a picture of participation that does not represent the population served by the organization.

#### **2.4.2.1.3. Community Culture**

The learned values, behaviours and beliefs of a group will dictate how members of that group behave in given situations, making community culture a powerful influence on the characteristics of setting. Socioeconomic factors such as income, education and population size contribute to community culture and become issues in citizen participation. Participation in organizations is easier when citizens have more disposable income, when they have a basic knowledge of health issues, and when community structures are less formal. Therefore, the community's size, socioeconomic demography, and complexity influence participatory experiences.<sup>47, 48</sup> A community's historical experience with participation and the expectations that community has around participation are also strong influences.

Finally, the community's perceived degree of control over events and influence over organizations are sited as important cultural factors.<sup>47</sup>

#### **2.4.2.2. Central Concepts of the Conceptual Map**

The four central concepts of the Wiebe et al. model include characteristics and support of participants, characteristics of change, goals and objectives of participation, and characteristics of participatory techniques as they apply to communities.

##### **2.4.2.2.1. Characteristics and Support of Participants**

The inner elements of the model described by Wiebe et al. start with 'characteristics and support of public participants,' which refers to the knowledge and power balance between citizen participants and organizations.

Communities may have internal barriers which manipulate citizens or exclude certain groups. For example, some communities have very low levels of "personal wellness and self esteem (making them) unable to participate effectively."<sup>24, p 84</sup> Bopp et al. describe this as 'poverty of means,' and explain it includes barriers to the participatory process. These barriers are the costs of participation – including "human energy, money, time, transportation, child care, household security ... in short anything that people would have to sacrifice in order to be able to participate."<sup>24, p 86</sup> Special supportive steps must be taken to ensure marginalized citizens have equal opportunity to participate.

##### **2.4.2.2.2. Characteristics of Change**

The 'characteristics of change' element refers to the dynamic nature of change and the influence that the speed and degree of change has on the success of citizen participation. Effective development involves change, and happens at four levels: individual change, organizational change, community change and social change.<sup>37</sup>

These levels are separate but linked; change in one area will influence change in the others. Individual and community change will happen as citizens participate in increasing numbers in organizations; however, the greatest experience of change will be within organizations that have historically been relatively closed to citizen involvement. Wider-scale organizational change will be required if there is to be meaningful partnership between citizens and organizations.<sup>37</sup> Therefore, in the context of this research, ‘characteristics of change’ has the most significance related to organizational change and is discussed later in this chapter.

#### **2.4.2.2.3. Goals and Objectives of Public Participation**

The model elements ‘goals and objectives of public participation’ and ‘characteristics of participatory techniques’ fit closely with the ladder of participation, in that identified goals for a project and techniques used to increase participation will be entirely dependant on how high up the ladder of participation an organization has moved.<sup>6</sup> The goals of participation are discussed here.

While a high degree of value is placed on citizen participation in health care decision-making, experience has shown that “programs involving (citizen) participation do not always meet expectations, either in terms of getting people to participate or in terms of improving people’s health.”<sup>38, p 305</sup> However, in the spirit of community development, it must be considered that even if the program did not meet professionals’ expectations, perhaps outcomes met the needs of the citizens and fostered empowerment. Conversely, the process of participation may meet the organization’s objectives but may not meet the needs or expectations of the citizens. Inherent in this debate is the concept of participation as a process (or as a means to an end) and participation as an outcome (or as an end in itself). The literature reveals discussion of both objectives.<sup>4, 5, 17, 34, 45, 47, 49</sup>

Participation as an outcome is better understood in the context of the determinants of health. Research shows that populations with a greater degree of self determination enjoy many benefits, including development of skills, knowledge, and experience; healthy changes in lifestyle; and longer life expectancies and better overall health.<sup>37, 50</sup> In a report on community development and public participation, the Winnipeg Regional Health Authority quotes the World Health Organization stating “the benefits of meaningful community participation are health enhancing in themselves and include increased responsiveness, increased competency and capacity, better decision-making, an extension of the democratic process, creativity and innovation.”<sup>25, p 5</sup> It can be imagined that the provision of opportunities for meaningful participation in the structures of organizations that are fundamental to a citizen’s well being, such as health care services, will improve the health of individuals and communities.

In a review of the evaluation models of community participation, Boyce argues that most reviews of participation focus on efficiency and minimize citizen empowerment as an outcome.<sup>51</sup> Citizen and community empowerment, as discussed earlier, can be viewed in terms of ‘participation as an end in itself’ and the literature reinforces its significance as an outcome of participation.<sup>27, 45, 52, 53</sup> A sense of ‘ownership’ is an important prerequisite to empowerment, and ownership is influenced by the intent of participation, both from the citizen’s perspective and the organization’s perspective.<sup>38</sup>

The citizen’s right to be part of decision-making, which will direct his or her health care either individually or globally, is an essential part of the philosophy of primary health care. Equity and social justice are root values of this philosophy and are important outcomes of citizen participation. In a health care environment increasingly focused on the principles of consumerism, primary health care and

equal citizen participation address discrepancies in society. Primary health care must remain connected to its values of fairness, equity, justice and caring.<sup>43, 54</sup>

Accountability is a concept often associated with organizations; however, citizens are also accountable for their participation in health care decision-making. A dilemma is created when a citizen is faced with a situation where the citizen's individual needs may not be met by the direction the organization is taking in the interest of the greater good of the population.<sup>9, 34, 41, 44, 46</sup> This situation must be carefully facilitated by the organization, and ethically weighed by the citizen.

#### **2.4.2.2.4. Characteristics of Participatory Techniques**

Organizations tend to view communities through the lens of that organization's agenda: the education system focuses on community needs related to learning, health sees issues related to disease and health determinants, and private industry views the community in terms of financial wealth and spending ability. Alternatively, citizens view their community from the perspective of living in the environment from day to day. This results in a view that is 'greater than the sum of the parts' and citizens see the community as a whole in terms of the broader community picture. Consequently, priorities for citizens will be related to those issues which are most pressing for day to day existence. Participatory techniques must allow for spontaneity to accommodate issues of importance to citizens, which may or may not align with the issues of importance to health care professionals.<sup>49</sup>

If an opportunity for all citizens to participate is a goal of an organization, then participatory techniques must be used which will reach those citizens who are generally harder to engage and who may not represent the predominant social group. Focus groups or engaging peer outreach at high schools or drop-in centres,

accessing moms' groups and minority cultural groups, are examples of ways to accomplish this.

### **2.4.3. Organizations**

Organizational development was conceived before 1960 and has become an area of increasing interest.<sup>55, 56</sup> Literature in the field has grown significantly since the mid 1980's when the leadership of corporations began to recognize the value of investing in and developing the 'softer skills' of business management, such as organization culture and behaviour.<sup>14</sup>

Examining the interaction between citizens and organizations requires the application of both community and organizational perspectives in order to gain a full understanding of citizen participation in health care decision-making. Citizen participation is fundamental to community development, and organizational capacity must be such that citizens are empowered to participate.<sup>25</sup>

While organizational development and community development are fundamentally different, they exist in parallel universes, the literature shows they share some commonalities. These commonalities include language of development, skills and resources. Most importantly, communities and organizations share one basic common denominator: people. Rather than visualizing organizations and communities as parallel, it may be more accurate to describe organizations as microcosms of the communities within which they function since organizations are communities in their own right and exhibit similar behaviours. The obvious difference for organizations is the expected outcome, which is the delivery of a product or a service for a profit of some kind.

#### **2.4.3.1. Organizations as a Concept**

Organizational behaviour literature echoes community development literature in claiming that organizations are political and social entities.<sup>21</sup> And, like society is composed of individuals, families and communities; organizations can be studied from three levels: individuals, teams and the institution. Since characteristics that describe communities are also applicable to organizations, the Wiebe et al. conceptual model is now used to discuss characteristics of organizations.

##### **2.4.3.1.1. Characteristics of Setting**

As with the discussion of ‘characteristics of setting’ for community, the encompassing characteristics of setting are described for organizations in terms of 1) capacity, 2) power, 3) social capital, 4) development and behaviour and 5) culture.

##### **2.4.3.1.1.1. Organizational Behaviour, Development and Capacity**

McShane asserts it is important to study organizational behaviour for three reasons. The first is to satisfy the need to predict and understand events in order to discover relationships and capitalize on them. Second, organizations must have an accurate understanding of the workplace and employee reality and therefore act appropriately in the given circumstances to optimize output. The last reason to study organizational behaviour is to control organizational events in order to “make better decisions, structure organizations to fit the surrounding environment, improve individual performance, build employee commitment, and help work teams operate more effectively.”<sup>21, p 11</sup>

Organizational behaviour models are helpful in conceptualizing characteristics of setting for organizations. Senge suggests that structure influences behaviour, and developed an organizational behaviour model based on the philosophy of learning and open systems in organizations.<sup>14</sup> ‘Systems thinking’ diverges from the

traditional top-down organization in which change is a linear, ‘applied’ process, to an organization which is interactive and change is accomplished through a series of interrelationships. Systems thinking results in a holistic philosophy where decisions and changes made in one area are considered very carefully for their effect on other areas of the organization. Organizational change is accomplished through the development of shared vision and common purpose.<sup>14, 21, 52</sup>

Organizations depend on acquiring resources from the external environment, such as information, financial support and human resources.<sup>21</sup> External environments are always changing and the systems view illustrates how organizations can experience success, for a system that has open connections with the ever-changing external environment will adapt more quickly than others and therefore survive.<sup>21</sup> A ‘survival of the fittest’ mentality may seem distasteful in a publicly-funded health system, however the reality is that health care demands are changing and health service delivery must change to meet the needs of citizens.

Organizational development and organizational capacity are similar to their community counterparts as described in section 2.4.2.1. The development process enhances organizational capacity, just as community development enhances community capacity. Organizational development and community development share some basic philosophies, such as: they are both deliberate strategies to manage change, they both focus on capitalizing the human potential within the group of interest, and they both “assist the effectiveness, capabilities and adaptability of the (group) by improving the processes by which people get things done and the relationships between people.”<sup>37, p 207</sup>



#### **2.4.3.1.1.2. Organizational Culture**

Organizational culture is discussed in the literature as a significant factor in organizational development and capacity. Organizational culture, like other types of culture, is the shared beliefs and values of the organization and behaviour patterns that are taught to employees.<sup>20</sup> As with other types of cultures, conformity to organizational values and beliefs has social and professional consequences, and adopted behaviour patterns are soon evident among new members. Cultural values and beliefs can be assimilated from the environment over time, or culture can be developed or changed through strategic actions such as active recruitment of individuals with desired values and traits through the development of job descriptions and expectations.

Attitudes of professionals working in a participatory environment are an invisible manifestation of values and beliefs, and therefore become part of the organization's culture. "Attitudinal barriers are not usually written down, but they are the most potent of barriers because, as reflections of cultural values and beliefs, they lead to the codifying of these values as legislation, regulations, and policies."<sup>57, p 9</sup> Attitude is key to the way the participatory process is facilitated, and can lead to either empowerment or disempowerment of citizens and communities.<sup>24</sup>

An additional attitudinal barrier within health care organizations is the ingrained perception of both providers and citizens about what constitutes health care. Since the advent of Medicare, Canadians increasingly equate 'health' with 'institution' and acute care services. Within health care as an organization, much less emphasis is placed on health promotion and illness prevention. Investments in the influence of the root causes of ill health are very small as compared to more immediately pressing acute care needs.

Provider attitude is further compounded by the lack of understanding of the philosophy of primary health care. Traditionally, post secondary education programs prepared professionals in isolation from each other and a team philosophy was absent from curriculum. The literature reveals a call for changes to the way health care professionals are educated in basic training, to ingrain a team philosophy and primary health care approach to care.<sup>58</sup> Post secondary institutions have responded and more new professionals entering the health care system today are being prepared in a primary health care philosophy.

#### **2.4.3.1.1.3. Power**

Power as a characteristic of setting was introduced earlier in this chapter. In the original CiPPP research, a focus on the concept of power was avoided due to the abundance of literature on power structures within organizations.<sup>59</sup> However, power remains an important influence on characteristics of setting for citizen participation and is reinforced by structures such as the organization hierarchy and the formal and informal power relationships that are created by this hierarchy. Particularly important to the organization setting is the power imbalance intrinsic to knowledge differences, and the importance of the transfer of that knowledge to equalize power among participants. Conflict is inevitable in this process as those with power struggle with the obligation to share it. Consequently, power becomes an important element of the social capital of an individual, organization or community.

#### **2.4.3.1.2. Central Concepts of the Conceptual Map**

The following sections discuss the four central concepts of the Wiebe et al. model, including characteristics and support of participants, characteristics of change, goals and objectives of participation, and characteristics of participatory techniques as they apply to organizations.

#### **2.4.3.1.2.1.Characteristics and Support of Participants**

“Health development structures will only be able to flourish where national health policies offer a strong endorsement of a perspective on health based on a social, economic, political and environmental understanding of health and disease.”<sup>47, p</sup>

<sup>106</sup> Legislation and political will are cited in the literature as the most important organizational factor in supporting public participation. This kind of support does not come easily due to the long-term investment required by prevention efforts, related to much shorter political career life expectancies. It takes years, if not decades, to show community or society-wide improved health due to investments in ‘upstream’ interventions on the determinants of health, and historically legislators have been reluctant to take this political step.<sup>38</sup> However, we are seeing changes in this attitude as more recent elected officials support the implementation of citizen participation in health care decision-making.<sup>2, 60, 61</sup>

Professional dominance, knowledge imbalance, and access to policy makers combine to put organizations in a distinct position of authority over citizens.<sup>8, 9</sup> Health care organizations are entrenched institutions which hold a respected and revered position within our society. It can be intimidating for citizens unfamiliar with the culture of health care to become involved with the institution; further, this involvement implies accountability and representativeness, and requires a commitment of personal resources including knowledge and time.<sup>9, 41</sup> These elements combined effectively eliminate the possible participation of many citizens, particularly those who may be at the lower end of the socioeconomic scale and therefore at higher risk for health concerns due to the negative influence of the determinants of health. Citizens will participate to the degree to which they are supported to do so, and it is critical for organizations to be sincerely committed to the participatory process, share knowledge with participants and act as advocates for citizen participants.

#### **2.4.3.1.2.2.Characteristics of Change**

The process of change is discussed by a number of authors and identified as an important element in how organizations support or inhibit citizen participation.<sup>6, 9, 37</sup> While change is a normal and necessary life experience that happens at various rates and levels,<sup>52</sup> a number of factors present barriers to change. It takes energy to learn to do things differently and to commit to change. People will feel threatened by the unknown, and resistance can be even greater if information is not freely shared with them. Change usually represents loss – of power, relationships and responsibility.<sup>6, 52</sup> Finally, from both the citizen and organization perspective, barriers are created if there is no ownership in the change itself due to lack of participation in the change. These conditions must be acknowledged and planned for when organizations enter into the process of planned change.

Health care structures are not easily changed, and power structures are even harder to penetrate and alter. The power imbalance between health care providers and citizen participants in decision-making is related to differences in resources, status and knowledge.<sup>9</sup> Health providers may have a vested interest in maintaining the status quo and citizens may defer to provider opinion in the belief the health care provider's knowledge is superior. The literature suggests that the development of citizen participation structures will somehow reduce this inequity in power.

A shared power worldview is a significant shift in philosophy for most organizations, and all levels of the organization will experience change. Change does not appeal to all, and people may choose to leave an organization as it moves from a top-down hierarchy to one with a flatter organizational structure and expectations of shared power.<sup>21, 52</sup> The potential loss of skilled personnel is a concern to organizations. While other skilled professionals with values that are in

line with citizen participation can be recruited, it takes time and resources to recruit and train them and return to the previous level of productivity. This disadvantage must be weighed in the balance of benefits of increasing citizen participation.

Organizational change literature has shown a shift from a traditional top-down change approach, to a focus on how leaders can support the involvement of people within the organization and access their knowledge to promote a positive change experience.<sup>14, 52</sup> This shift mirrors the approach taken by community and is an example of how community and organizational development are similar.

#### **2.4.3.1.2.3.Goals and Objectives of Participation**

An increasing body of literature exists to support the importance of transparency and accountability in health care, as they are seen as common indices of citizens' trust in organizations. Accountability is measured at three levels: first, health care providers to the citizens they serve; second, organizations to the communities in which they are located, and third, political bodies to the public.<sup>9, 62</sup> Transparency related to motivation for change and public participation as well as development of legislation and use of public funds has influence at each level and is an important prerequisite to trust relationships.<sup>5, 9, 62</sup>

Citizens often do not recognize that health care organizations are caught in an accountability dilemma. On one hand, health care organizations sincerely aspire to provide services that are appropriate, accessible and sustainable to the communities they serve; services which address the community's unique determinants of health. After all, members of these organizations are also members of the community. On the other hand, these same organizations are funded by and fiscally responsible to political bodies which are removed from the communities. These political bodies often impose program requirements as a

condition of funding, and these programs may or may not reflect priorities identified by the community.<sup>5</sup>

Efficiency of service delivery is an important outcome for organizations, and can be considered from a variety of perspectives. First, efficiency at a basic level depends on clients making use of services that are offered. Therefore, organizations have a genuine stake in ensuring services are appropriate for and therefore utilized by the clients they serve. The literature shows that engaging citizens in health care decision-making will create health services that are appropriate for local needs and acceptable to populations, therefore utilized in the present and sustainable into the future.<sup>4, 41, 60</sup> However, Charles and DeMaio argue there is little research evidence to substantiate the belief that public participation will lead to more effective and more acceptable services for the community served.<sup>9</sup>

Citizens are wary that an unspoken goal of increasing citizen participation is to delegate decision-making responsibility for unpopular decisions to the local level, thus shifting final accountability away from traditional decision-making bodies.<sup>44</sup> Some see the shift in emphasis toward individual and community responsibility for health as an abdication of responsibility in the name of financial efficiency on the part of the health care system.<sup>47</sup>

#### **2.4.3.1.2.4.Characteristics of Participatory Techniques**

‘If you build it, they may not care’ is perhaps a maxim that organizations should keep in mind when designing participatory techniques. An assumption related to citizen participation identified in the literature is that implementing citizen participation opportunities in CHCs will result in citizens eagerly seizing the opportunity to participate.<sup>49, 63</sup> It is further assumed that citizens who choose to participate will be representative of all members of the community served, not

just those who belong to the demographic majority, are educated, who belong to upper middle class strata, and/or with pre-existing positions of power. This illustrates the importance of involving citizens right from designing appropriate ways for citizens to participate.

Citizen participation cannot be assumed; it must be cultivated along with trust and commitment. Then, structures must be reinforced to make the participation meaningful.<sup>49</sup> The structure of traditional participatory techniques will influence who will participate, and citizens must “see some reflection of themselves”<sup>63, p 32</sup> in order to feel comfortable with the process and for trust to be established. It must be recognized that participation is a dynamic process, where the citizen moves through a series of stages from passive recipient to active participant with direct involvement.<sup>49</sup> Organizations must keep these personal developmental stages in mind when designing participatory techniques.

#### **2.4.4. Conceptual Models and Participation**

In summary, the Charles and deMaio matrix of participation and the Wiebe et. al model of factors influencing participation were used in this thesis as conceptual maps to guide the development of the secondary research. In the original research, a different model was created by the principal investigator as the conceptual map to describe the findings from that work. These two models were chosen for this thesis work because they describe citizen participation as a dynamic, non-linear process which fit the definition of participation in this thesis. The Charles and deMaio matrix was used as a guide to describe the environment, levels and goals of participation; and the Wiebe et. al model was used to describe the factors and elements that influence participation within that environment. In Chapter 5, the findings of this thesis are discussed within the context of these two models.

## **2.5. 'Health Care System' as an Organization**

The Medical Care Act of 1966 and the Canada Health Act of 1984 ensure that Canadians have comprehensive, universal, portable, publicly administered, and accessible access to medical insurance; and we pride ourselves on what is considered one of the best health care systems in the world.<sup>8</sup> The following section places health care within the context described in this chapter to this point.

### **2.5.1. History and Structure of Health Care Systems**

Organizational development literature focuses on organizations located in the for-profit and non-governmental sectors. Therefore, in order to examine health care organizations within the context of organizational development literature, it is necessary to compare health care systems to for-profit organizations, .

Health care as a concept and service is often considered in an organizational category by itself because of our pride in the system and the fact that services are managed publicly through federal and provincial political bodies at no direct cost to citizens. However, upon reflecting on the definition of organizations,<sup>21</sup> it is obvious that health care organizations are also social and political entities in which people work together in patterned behaviours to accomplish goals. Therefore, it must be recognized that health care organizations function under the same 'rules' as any for-profit organization large or small and are subject to the same rules of management and development, and the accompanying glories and pitfalls.

Provincial governments have primary responsibility for providing health care services to citizens and the challenge is how to get services to the client in an equitable way. The Canada Health Act states that Canadians have comprehensive, universal and accessible access to medical *insurance*; it does not say that they have comprehensive, universal and accessible access to medical



*services*. In fact, the discrepancies in accessibility to services are partly what spurred health care reform across the nation over the last decade.<sup>8</sup>

Regionalization and decentralization have occurred in almost every province in an attempt to increase citizen participation and control over health services and to create a health system with greater flexibility and responsiveness to local needs.<sup>2, 8, 61</sup>

### **2.5.2. Primary Health Care**

A commonly held belief is that the health care system as it exists cannot sustain itself under current conditions. The cost of providing services as we currently know it is increasing exponentially, and various employers are competing for scarce human resources.<sup>2</sup> Recent reviews conducted provincially and nationally indicate that our health care system can be sustained, but sustainability will require fundamental change in philosophy and practice.<sup>2, 61</sup> Part of the recommendations put forward as a result of these reviews was the strengthening of primary health care, including citizen participation in the planning and evaluation of health care services.

Primary health care as a service delivery method has been identified as the ‘magic bullet’ for what ails health care as a system. Consequently, many human and financial resources have been targeted for primary health care renewal in Saskatchewan and across the nation.<sup>2, 60, 64</sup> However, primary health care as a philosophy is very old. Community practitioners have always practiced believing in the values of community development, community participation, teamwork and intersectoral approaches, and attention to the bigger picture of the community by taking action on the community’s unique determinants of health. Therefore, the characteristics of setting for communities as discussed in section 2.4.2.1 are fundamental to the delivery of primary health care services.

Intersectoral networking appear in both the community development literature and the organizational development literature, and deserves special mention as one of the principles of the primary health care philosophy.<sup>17, 36, 53, 54</sup> Since most of the determinants of health are found outside the ‘control’ of traditional health services, the creation of partnerships with other agencies and community members is of paramount importance. Working with other organizations takes special effort and commitment, since all parties bring their own agendas to the table and common ground must be developed. Further, not all organizations will be at the same stage of development or have the same human and financial resources. The purpose of these interagency alliances is to develop effective community action beyond that which each would accomplish alone. Therefore, it is in the best interest of citizens and communities for agencies to learn to work effectively together in order to provide the best services to the communities they serve. Citizen participation may be enhanced through interagency alliances, as agencies become less isolated from each other and through these alliances become a forum to engage citizens.

### **2.5.3. Community Health Centres**

According to Church et al., CHCs are “community based organizations that provide a range of primary health and social services through teams of health and social services professionals.”<sup>15, p 1</sup> CHCs have been increasingly utilized as a source of primary health care services in Canada in the last 30-50 years.<sup>8, 15</sup>

From a service provision perspective, holistic health care within a primary health care philosophy necessitates consideration for the spectrum of health and social needs of clients, and for seamless service delivery from one program and setting to another. Traditionally, health services are fragmented and insulated, and a referral is as close to teamwork as many care providers get. Consequently, clients may experience poor coordination of services and often must enter the health care

system at multiple points.<sup>8</sup> Clients unnecessarily repeat the experience of entering and navigating the health system, repeating their health history to multiple providers and possibly omitting critical information. From a provider perspective, this represents the potential for duplication of services or missed intervention opportunities. Shah suggests the community health centre is a good model of integration of health and social services.<sup>8</sup>

CHC organizational structure and management in this research includes centres that are developed and managed by regional health authorities, and centres that are managed by community boards in the district in which the CHC is located. The subtle difference between these two types of sites appears to be related to two things: the point in time the site was developed (pre-regionalization vs. post-regionalization) and the degree of citizen involvement in the day-to-day management and running of the site.<sup>15</sup> These types of sites hold in common the philosophy of holistic primary health care, where health care providers work on teams as equal members. In many cases, physicians are reimbursed by means of an alternate payment arrangement rather than through the traditional fee-for-service structure, although this is more common in the centres managed by community boards. The team structure is strengthened through this arrangement since a physician's income is not tied to numbers of clients seen, and the physician's clinical expertise can be focused on clients with complex and time-consuming health issues. Clients can access care from the most appropriate care provider for their health concern when they need it.<sup>2, 60</sup>

The first type of CHC is that which is developed and managed by regional health authorities, and are primarily the result of post-regionalization and primary health care renewal efforts in the provinces.<sup>15, 60, 64</sup> In Saskatchewan, the focus of these CHCs is the development of primary health care teams and the implementation of nurse practitioners.<sup>60, 64</sup> The team members at these sites may report to various

regional health authority managers who are ultimately responsible to the CEO and health authority board of directors. Operational decisions and issues are the responsibility of the managers as the workings of the CHC are but one of many regional health authority issues that concern the health authority board.

The second type of CHC is one that Church refers to as ‘stand-alone.’ These CHCs were “developed as autonomous community organizations prior to the introduction of regional/district health authority structures ....”<sup>35, p 4</sup> Citizen health boards run these sites, and the governance of these organizations is not linked to the Regional Health Authority structure within which they are geographically located. There may be administrative linkages between the Health Authorities and the stand-alone CHCs in the form of contracts for sharing of services or programs.

#### **2.5.4. Organizational Structures and Processes which Obstruct or Facilitate Citizen Participation in Health Care**

The elements identified in the literature of organizational structures and processes which obstruct or facilitate citizen participation are synthesized into the framework presented by Wiebe et al. The details of the elements of this model are found in Figure 2.4 and 2.5.

Figure 2.4

Organization and Community Factors which Facilitate or Obstruct Citizen  
Participation in Health Care Decision-Making: Synthesis of the Literature  
Reviewed (Overview)

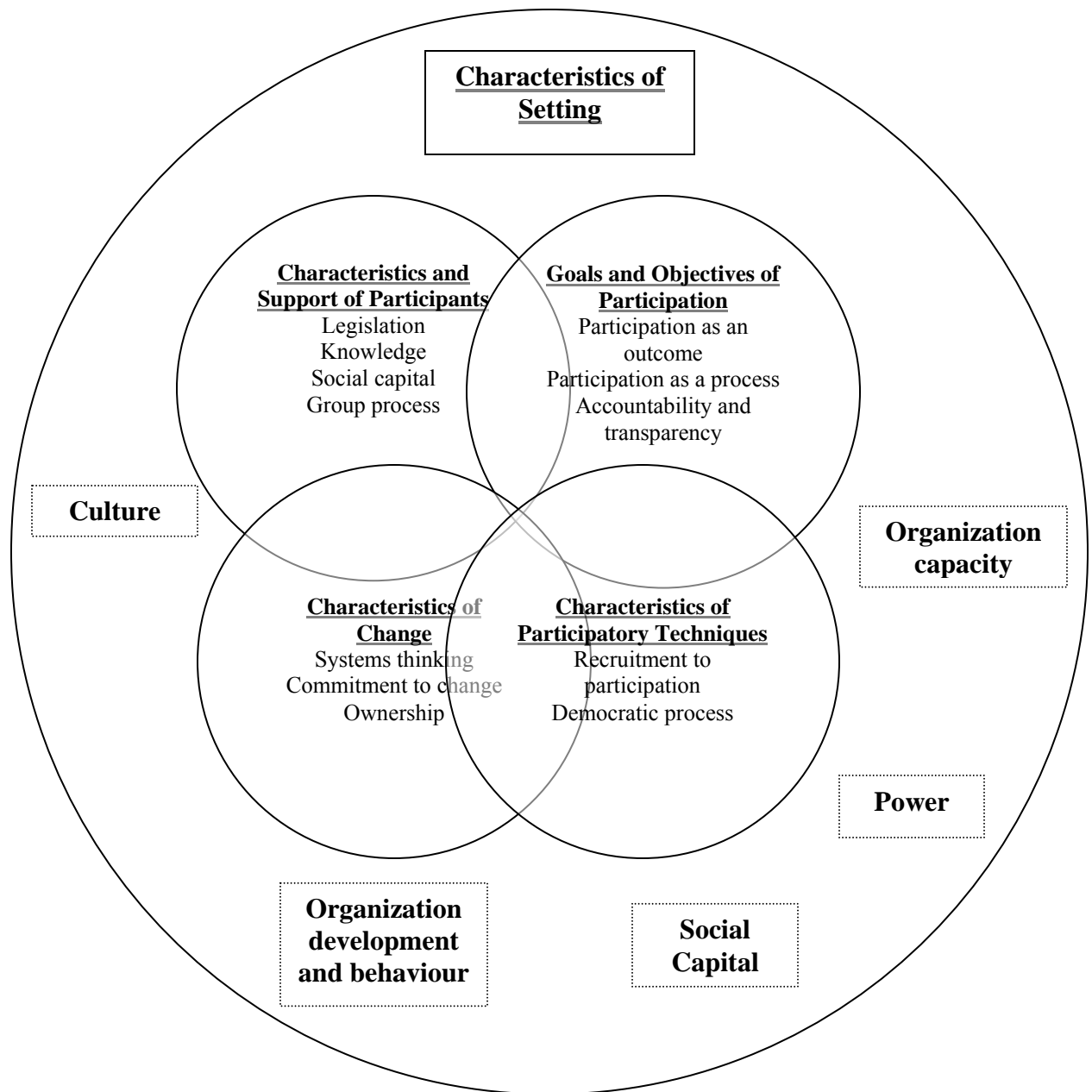


Figure 2.5

Table of Organization and Community Factors which Facilitate or Obstruct Citizen Participation in Health Care Decision-Making: Synthesis of the Literature Reviewed (Discussion of Factors)

<b><u>Characteristics of Setting</u></b>	
<b>Organization Capacity</b>	<ul style="list-style-type: none"> <li>• Research</li> <li>• Team capacity <ul style="list-style-type: none"> <li>○ Skill at working together</li> <li>○ Atmosphere of team learning</li> <li>○ Horizontal integration with other agencies</li> <li>○ Communication between levels of bureaucracy and to communities</li> <li>○ Skill development and training for staff; volunteers</li> <li>○ Staff dedicated (by philosophy and job description) to development and participatory work</li> <li>○ Recruitment of staff (and volunteers) with interest and specific skills in participatory work</li> <li>○ Minimal competition between organizations for resources and within organization for distribution of resources</li> </ul> </li> <li>• ‘On the ground’ application of participation and teamwork philosophy <ul style="list-style-type: none"> <li>○ Written goals, objectives and strategic plan that is communicated within the organization and to the community</li> <li>○ Method of measuring progress</li> <li>○ Structures allowing communities and organizations to work together</li> <li>○ Incentives for organization, professionals and citizens to work together</li> </ul> </li> <li>• Practical methods for action developed</li> </ul>

<b>Power</b>	<ul style="list-style-type: none"> <li>• Mutual respect and equal partnerships with citizens</li> <li>• Sharing/distributing of power among health professionals as well as with citizen participants</li> <li>• Staff sees self as ‘facilitator,’ not ‘owner’</li> </ul>
<b>Social Capital</b>	<ul style="list-style-type: none"> <li>• Social will</li> <li>• Recognition of community social capital (repeated under “Characteristics and Support of Participants”) <ul style="list-style-type: none"> <li>○ Recognition and removal of barriers to participation</li> <li>○ Local and experiential knowledge</li> <li>○ Skill development and values-based training for participants</li> </ul> </li> </ul>
<b>Organization Development and Behaviour</b>	<ul style="list-style-type: none"> <li>• Developmental maturity of the organization</li> <li>• Political will</li> <li>• Resource allocation and development support</li> <li>• Shared vision within the organization and shared goals for the whole community</li> <li>• Supportive organizational structure (is commitment evident?) <ul style="list-style-type: none"> <li>○ written into key organizational documents</li> <li>○ Commitment to the process and facilitation of development and meaningful citizen participation (from the top of the organization down)</li> <li>○ Stakeholder approach to service delivery</li> <li>○ Levels of decision-making minimal</li> </ul> </li> <li>• Understanding and acceptance of the political context (i.e.: bureaucracy: reporting to government agencies)</li> </ul>
<b>Culture</b>	<ul style="list-style-type: none"> <li>• Attitude translation into policy <ul style="list-style-type: none"> <li>○ <i>Kind</i> of post-secondary education preparation of organization members (i.e.: does it include a team philosophy to health care delivery?)</li> </ul> </li> <li>• Community and organization’s prior experience with</li> </ul>

	<p>participation (either positive or negative).</p> <ul style="list-style-type: none"> <li>• Holistic view of community</li> </ul>
<b><u>Characteristics and Support of Participants</u></b>	
<ul style="list-style-type: none"> <li>• Legislation/political will</li> <li>• Knowledge distribution</li> <li>• Recognition of community social capital <ul style="list-style-type: none"> <li>○ Recognition and removal of barriers to participation</li> <li>○ Local and experiential knowledge</li> <li>○ Skill development and values-based training for participants</li> </ul> </li> <li>• Group process: <ul style="list-style-type: none"> <li>○ Facilitation skills (all members encouraged to share views; facilitator debrief with members; climate of mutual respect; conflict acknowledged and addressed).</li> <li>○ Allow time for participation to develop (accept that the process of collaboration is developing and changing).</li> <li>○ Balance between awareness creation for participants and health activities</li> <li>○ Established group principles to guide governance (written in policy)</li> </ul> </li> </ul>	
<b><u>Characteristics of Change</u></b>	
<ul style="list-style-type: none"> <li>• ‘Systems thinking’ approach to change <ul style="list-style-type: none"> <li>○ Holistic view of the organization as a system rather than focusing on isolated parts (i.e.: how will change in one area effect change in other areas?)</li> <li>○ Interconnectedness</li> <li>○ Structure influences behaviour</li> </ul> </li> <li>• Commitment to change</li> <li>• Ownership of outcomes of change</li> </ul>	



<b><u>Goals and Objectives of Participation</u></b>
<ul style="list-style-type: none"> <li>• Participation as an outcome: <ul style="list-style-type: none"> <li>○ Willingness to share ownership and support of local ownership to community</li> <li>○ Citizen participation and ownership throughout the entire process (planning through implementation and evaluation)</li> <li>○ Mutual respect and equal partnership</li> </ul> </li> <li>• Participation as a process: <ul style="list-style-type: none"> <li>○ Decision-making to include expert and non-expert knowledge</li> <li>○ Flexibility in project objectives and outputs to accommodate citizen's needs and input</li> </ul> </li> <li>• Accountability and transparency <ul style="list-style-type: none"> <li>○ To communities</li> <li>○ To government</li> </ul> </li> </ul>
<b><u>Characteristics of Participatory Techniques</u></b>
<ul style="list-style-type: none"> <li>• Recruitment to participation <ul style="list-style-type: none"> <li>○ Traditional methods vs. actively seeking populations of interest</li> <li>○ Development of non-traditional ways to participate (storytelling, sharing experience)</li> <li>○ Organization members actively go where citizens are (churches, coffee shops, worksites)</li> <li>○ Celebrate local and experiential knowledge</li> <li>○ Actively engage and enable marginalized groups to participate in a familiar and comfortable environment (“see themselves in the process”)</li> </ul> </li> <li>• Ensure democratic process for decision-making <ul style="list-style-type: none"> <li>○ Be aware of professionals manipulating and aligning with citizens in order to build power for a particular position</li> <li>○ Ensure manipulation does not happen when consensus is not possible</li> <li>○ No ‘rubber stamping’ if communication is ineffective</li> </ul> </li> </ul>

## **2.6. Conclusions**

This chapter describes the logic of the research design within the context of existing community participation research. My literature review focused on bringing community development literature and organizational development literature together. Conceptual models of citizen participation were used as a lens to develop a research approach that considered community development and organizational development knowledge. To a lesser degree, my literature review identified gaps in existing research. The literature review done by the original CiPPP team focused on gaps in existing research, which informed the development of the research questions of the original CiPPP research and consequently my research question.

Several important concepts arise on a review of the literature of community and organizational development and the resulting influence on citizen participation in health decision-making.

The literature shows consensus that citizen participation in health care decision-making is a *good* thing; whether this participation actually leads to improved health care outcomes is an area of debate. However, the grassroots origins of the participation movement demands organizations move in the direction of greater accountability and transparency. Organizations must work hard to ‘step out of the comfort zone’ of traditional participatory efforts and systematically develop meaningful participation practices and environments in order to gain the trust and participation of all citizens, not just those with education and means.

Primary health care, community development and organizational development are similar concepts although the fundamental basis of each may be different. The change process, interagency partnerships, teamwork, and development processes are applicable to the philosophies of each of the three concepts. It is clear the spheres in the model presented by Wiebe et al. overlap and interact. The process

and outcome of this dynamic interaction is what eventually fits into the matrix model of dimensions of participation. Within the Charles and deMaio model (see Figure 2.2,) it can be anticipated that citizens' greatest participation and influence will be found in the dimensions of service, policy, and consultant/partnership given the evidence in the literature.

In summary, I found few references in the literature that compared and contrasted community development and organizational development philosophies. This gap connects to my global research philosophy, which sought to determine how organizational development processes inform and support community development processes. The literature provides many descriptions of community development models and organizational development philosophy, and why each is beneficial to community development and organizational development respectively. Many examples of practices that facilitate or hinder participation were identified through the literature search, but no 'best practice gold standard' was identified for citizen participation. What is not known is how community development philosophy and organizational development philosophy inform each other, and how the two interact to create an environment conducive to the development of citizen participation best practices in health care organizations.

My specific research question regarding the identification of organizational behaviours and structures which enable or obstruct citizen participation in organizational decision-making in community health centres is addressed using a combined community and organizational development research approach, which I have identified as a gap in the literature.

The multiple levels of responsibility citizens bring to health care decision-making, the role perspective they choose, and the level of participation they are empowered to have are all influenced by the many factors discussed in this chapter. The dynamic process and results were of primary interest in the development of this thesis.

## **Chapter 3**

### **Methodology**

### **3. METHODOLOGY**

In Chapter Three, the methodology of the original CiPPP research is introduced. I describe how the original research utilized a participatory approach and employed a variety of inquiry techniques. I elaborate on how a mixed methodology approach was used within the framework of participatory inquiry in the original CiPPP research. I then describe the methodology used to examine the CiPPP findings for this thesis.

#### **3.1. Methodologies Used to Study Participation in Existing Work**

Qualitative research is described as “inductive, open and rich; often explain(ing) how and why interventions work by elaborating on the meaning of the findings.”<sup>65, p</sup>

<sup>160</sup> The scientific rigour of qualitative research is established through the concepts of validity, triangulation and thick description.<sup>66</sup> The issue of applying findings to other situations (“generalizability” in quantitative terminology) may not be of primary importance since certain aspects of human activity are context-specific. Helman contends that a qualitative approach is most useful in the examination of the social, cultural and economic contexts of health.<sup>67</sup>

Conversely, quantitative research starts with a hypothesis, which the researcher tries to prove or refute. Methods are “deductive, precise, objective, readily analyzed by computers, and often easily reproduced.”<sup>65, p 160</sup> Scientific rigour is established through methods such as randomization and experimental design.<sup>68</sup> Data produced by quantitative research is ‘low-context’ such as physiological counts and is objectively verifiable.<sup>67</sup> The context-specific nature of a primary health care setting

makes it impractical and inappropriate to apply strict quantitative methodology therefore ‘pure’ quantitative research is not always possible.<sup>67, 69</sup>

The literature demonstrates that a variety of methods have been used to study citizen participation in health care decision-making and primary health care. Traditional medical model health care concentrates on the process of disease rather than the social circumstances which may have caused or contributed to it. Consequently, the experimental design of quantitative research predominates in medical model primary health care research, and focuses on verifiable health outcomes related to specific interventions.<sup>67</sup> However, quantitative research generally “excludes such phenomena as context, meaning, worldview, religion, beliefs and behaviours, all of which are also relevant to mental or physical health.”<sup>67, p 112</sup> A broader definition of primary health care under a social sciences model demands that research reflect context as well as the root causes of ill health found within the communities.<sup>36, 70</sup> Consequently, an increasing number of researchers are using qualitative techniques to study primary health care in order to create a depth of understanding related to the context of an issue.

### **3.1.1. Mixed Qualitative and Quantitative Methodology**

Qualitative and quantitative research each has strengths and weaknesses and can complement each other when the methods are used together. This is known as mixed methodology.

In the literature, the integration of the two methods is described from the perspective of strengthening quantitative research. It is argued that data can be assessed with quantitative objectivity, while qualitative methodology adds ‘meaning’ to the findings.<sup>65, 66</sup> Applications for the use of mixed methodology are described by Tudiver et al. The authors argue that the methods “cross-validate each other, ... (help to) determine potential biases, ... the methods used together can add ‘richness’ or ‘thickness’ to quantitative study results, ... (and) adding qualitative

data in traditional randomized controlled trials (can aid) generalizability of the findings.”<sup>65, p 160-161</sup>

The original CiPPP research employed a variety of techniques to examine and describe the relationship between organizations and citizen participation. These techniques included surveys, focus groups and document audits with qualitative and quantitative analysis (see Figure 3.2, Part I). Therefore the original CiPPP research design may be considered to have employed a mixed methodology approach.

### **3.2. Setting: the Citizen Participation Partnership Project**

The Citizen Participation Partnership Project was a research project launched in 2001 by a team led by Dr. John Church of the University of Alberta. The purpose of the study was to “look at how people and communities work with CHCs to identify and respond to health issues.”<sup>15, p 2</sup> Citizen participation was compared in seventeen CHCs (representing eight provinces). The study had six objectives:

1. Conduct case studies comparing the nature and extent of citizen participation in 17 CHCs in eight provinces.
2. Analyze the relationship between citizen capacity to participate, organizational capacity to facilitate participation, internal and external influences, and policy/service outputs in CHCs.
3. Assess the impact of regional structures and processes on citizen participation in CHC decision-making.
4. Assess the impact of citizen participation on regional and CHC decision-making.
5. Identify facilitators and barriers to citizen participation in CHCs.
6. Disseminate research findings to decision makers, administrators, health service providers and communities.<sup>15</sup>

Further, the research raised the following research questions:

1. What is the relationship between level of participation (placation vs. joint decision making), role perspective (individual vs. collective) and decision making domain (policy, management, service delivery) of citizens in CHCs?
2. From the perspective of citizens, health professionals and health administrators, what factors facilitate/inhibit citizens to participate and CHCs to incorporate citizen participation into their decision making? (Community capacity, structures, processes, organizational philosophy/values, professional ethos?)
3. How is citizen participation incorporated into organizational decision making?
4. How does the input of citizens into CHCs decision making translate into service/policy outputs?<sup>15</sup>

The original CiPPP research used a participatory research approach, which by definition requires the involvement of the people who will benefit most from the research. Participatory research is built on the belief that citizens must take an active role in defining and examining their health needs and resources.<sup>28</sup> This participation will result in research methods that are acceptable to the community and research results that are meaningful.<sup>28</sup>

The original CiPPP research team collected data between February 2002 and April 2003. A participatory research approach can incorporate many methods of inquiry, including qualitative and quantitative approaches.<sup>28</sup> Three methods of data collection were designed: surveys, focus group discussions and interviews, and audit of key site documents. Rigorous tools were developed for each type of data collection.<sup>15</sup> Stakeholder groups were identified for data collection representing the broad categories of citizens, administrators, and health providers. Questions in the data collection tools were designed to reveal “perceptions of individual and community capacity, organizational capacity (structure, process, and culture), and outcomes (administrative and health).”<sup>15, p 2</sup> Of interest is the dynamic interaction between the organization and the people it serves, and how this relationship

ultimately changes both the organization and the stakeholders. As stated in the original CiPPP funding request, “organizational structures and processes will affect how issues are processed by (stakeholders), and in turn be affected by the interaction of (citizens, administrators, and health providers).”<sup>10, p 6</sup> In the spring of 2005, I was added as a researcher to the CiPPP project.

To date, data analysis is complete on quantitative information obtained from the CiPPP surveys, the results of which are discussed in this thesis. Qualitative analysis of the extensive focus group and interview information from the original CiPPP research is in progress and consequently unavailable for comparison to the data examined in my thesis.

Content analysis was carried out on key policy and practice documents from each organization. Reviewers used a standard audit document to evaluate current and historical documents provided by the participating CHC such as mission statements and job descriptions, with the goal of developing a picture of the organization’s values, principles, structures and processes related to citizen participation in the organization.<sup>35</sup>

The intent of this thesis was to attempt to identify structures of organizations that support or hinder citizen participation, as shown by key documentation. This thesis compares conclusions from the content analysis data to the quantitative findings of the CiPPP survey research and the satisfaction citizens felt in the level of participation they experienced in that organization.

### **3.2.1. Participants**

As this thesis is based on data collected in the CiPPP project, the participants are those who contributed to the original study.

The purpose of a participatory approach in research is to make the results of the research meaningful and applicable to those who use the services and work within



the system. CHC site selection in the original CiPPP research occurred primarily through self selection, in order to remain true to a participatory philosophy. Most sites expressed an interest in participation through self-selection following a contact by the CiPPP principal investigator. In some cases, employees were known to the principal investigator and were ‘shoulder-tapped’ for participation.

Another reason for self-selection in the original CiPPP research was an attempt to achieve a balance in type of CHC between those that were Regionally-run and those that were managed independently or ‘stand-alone.’ A concerted effort was made to attain a large enough sample of Regional and stand-alone CHC sites, and consequently in some provinces virtually all of one type of CHC or the other was included in the study.<sup>71</sup>

Seventeen CHC sites participated in the original CiPPP study, including two pilot sites. Prior to full rollout of the research to the remaining sites, the data collection tools and procedures were modified slightly based on feedback from the pilot sites. Consequently, data from the two pilot sites will not be included in this research.<sup>72</sup>

A document audit was not performed on Site Q (Figure 3.1) because “at the time (of data collection), the region was in transition and no formal policies were in place at the site. Given the radical shift in philosophy around community input and the resultant radical shift in structures and processes, old policies and documents were (considered) no longer relevant.”<sup>73</sup> As a result, this site is not considered in this phase of the research. From the remaining thirteen sites, 1150 individuals completed surveys. Discussion groups and one-on-one interviews were also held with some of these same participants.<sup>15</sup>

Figure 3.1  
Full rollout CiPPP survey statistics<sup>15, p 20</sup>

Site*	Administrators	Health Professionals	Board Members	Volunteers	Community Partners	Organized Client Groups	Walk-in Clients	Support Staff	Total
Site C	11	31	8	21	22	33	40	3	169
Site D	12	18	9	25	7	10	33	11	125
Site E	1	3	0	5	5	6	10	0	30
Site F	1	8	0	12	7	5	13	1	47
Site G	1	23	9	0	6	26	21	10	96
Site H	1	9	0	21	58	12	43	3	147
Site I	2	14	0	0	2	0	27	2	47
Site J	4	3	0	3	6	0	16	1	33
Site K	1	15	11	6	5	11	27	2	78
Site L	4	14	0	0	10	10	29	19	86
SiteM	4	10	6	9	10	0	17	3	59
Site N	4	12	4	1	18	24	23	2	88
Site O	1	7	2	0	7	13	18	2	50
Site P	7	25	13	0	7	12	43	5	112
Site Q		10					6	1	17
<b>Total</b>	<b>54</b>	<b>202</b>	<b>62</b>	<b>103</b>	<b>170</b>	<b>162</b>	<b>366</b>	<b>65</b>	<b>1167</b>

\* Sites A and B were pilot sites and data have been excluded from this research.

### **3.2.2. Factors Considered in Study**

A number of aspects of the CHCs included in the original research were taken into account in the development of the original research by the principle CiPPP researcher. First, organizational governance was considered and CHCs in the study were divided into two groups; those that were part of and managed within a larger Regional structure, and those CHCs that were managed by an independent board and considered to be 'stand-alone.' Participant type is the second aspect determined important to the original research design. Participants were divided into participant groups including clients, volunteers, health care providers, board members, and health care administrators. The last aspect of the CHC important to the original research structure is organizational processes. Examples of these processes are CHC policies, organizational structure, job descriptions and mission statements.

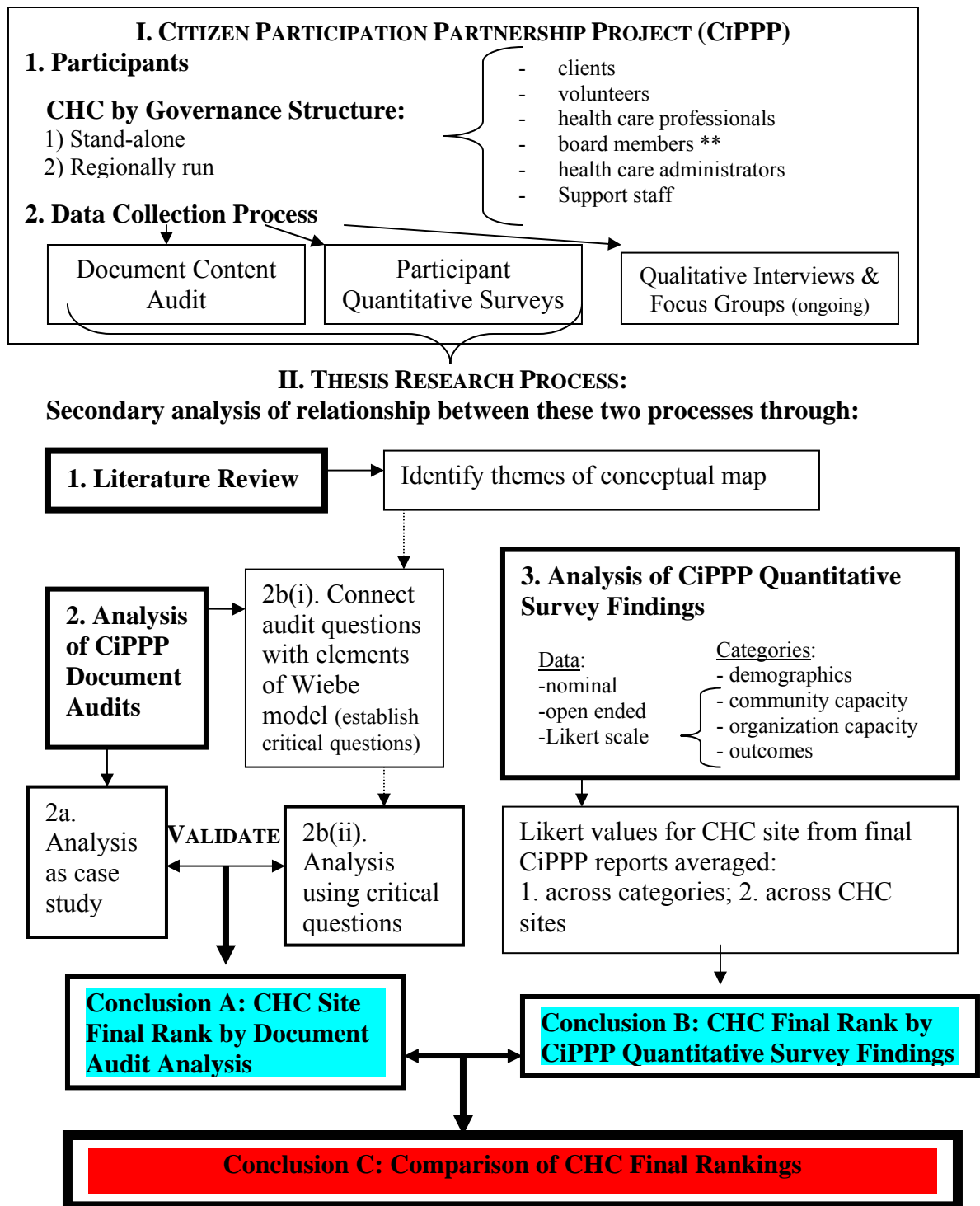
The factors described above become important in my analysis of the research since they inform the structure of the research and the original data collected, which is now used in a comparison of the document audit and the quantitative CiPPP research.

### **3.2.3 Procedure**

Both qualitative and quantitative methods were used in the original CiPPP research, making the original research a mixed methodology process. My secondary analysis of the original data was a descriptive and comparative process, using case studies of existing CHCs. The goal was to find a relationship between organizational processes and structures as found in organizations' key documents and the level of satisfaction with participation expressed by citizens (see Figure 3.2, Part II). I compared document audit data to quantitative findings of the CiPPP research, and the satisfaction citizens felt with the level of participation they experienced in that organization. Figure 3.2 summarizes the process used to examine the data.

Figure 3.2

Diagram of Thesis Research Process



\*\*Board members were not included in data collected from Regionally run CHCs.

### **3.2.3.1 Case Studies**

Salkind describes case studies as “a method used to study an individual or an institution in a unique setting or situation ... the researcher is as interested in the existing conditions surrounding the (organization) as much as the (organization itself). ... It is the quality of uniqueness that sets this (organization) ... apart from others.”<sup>68, p 193</sup> Case studies generate a great deal of detail and insight into a research question. The use of a variety of data collection techniques (interviews, surveys, document analysis) allows the researcher to establish validity, and the detailed insight into the issue allows for suggestion of further directions for research.<sup>68</sup>

The drawbacks of case studies include limited generalizability due to the nature of the research. The research results reflect the reality of what the researcher observed, therefore bear the inherent impression of his or her worldview. Finally, no cause/effect links between the factors of interest can be established, only a relationship between the two.<sup>68</sup>

### **3.2.3.2 Content Analysis Theory**

Gall et al. state the purpose of content analysis of documents is to “observe human behaviour and features of the environment in which the behaviour occurs. (Important features) of human environments (are) the messages that people encode in various forms.”<sup>74, p 356</sup> Written documents are the source of these messages in the original CiPPP research, and provide a window to the soul of the participating organizations—the values, beliefs, and practices related to citizen participation within those organizations. Formal documents such as mission statements, job descriptions, and pamphlets about services become the communication media with which the organization conveys the culture and norms under which it functions. These documents also become the source of information that citizens turn to when seeking information related to the value of participation within the organization.

Content analysis of documents can be quantitative research or qualitative.

Quantitative content analysis is conducted on records in which “the meaning of (the) text is assumed to be invariant across readers and across time.”<sup>74, p 362</sup>

Documents in quantitative content analysis are considered to be communications with official purpose. Job descriptions and mission statements are likely intended to be invariant across readers and time, and certainly are documents with an official purpose. Gall goes on to explain that with quantitative content analysis, the “meaning is in the text itself, and the meaning can be represented as discrete content variables and studied by the methods of content analysis.”<sup>74, p 362</sup> Although some of the documents in this research lend themselves to this kind of black and white analysis, most must be read with a degree of personal interpretation.

Qualitative content analysis of official documents is carried out with a degree of subjectivity. The meaning of documents is interpreted by the reader, and can have different meanings at different levels of evaluation.<sup>74</sup> Gall et al. suggest these documents must be studied in the context in which they were written in order to fully understand the document’s meaning.<sup>74</sup> For example, an organization’s vision statement is more completely understood when one can observe if and how these beliefs and values are applied in the organization’s daily work.

The final key difference between qualitative and quantitative content analysis is in the analysis phase. In quantitative analysis, a variable is chosen and applied consistently throughout the document review (such as word count) in order to obtain quantified data. Gall et al. propose the analysis procedure in qualitative content analysis evolves as the research develops, and results are not presented in a quantified form. Further, the same document can be evaluated at different points in the research process and reveal new insights; or it can be analyzed from different perspectives for different purposes.<sup>74</sup> Most of the CiPPP document audit data fits the description of qualitative data collection as outlined above.

### **3.2.3.3 Content Analysis Process**

I chose to prepare my study design and examine the answers to the document analysis questionnaires prior to accessing any results or conclusions reached by the original CiPPP team in order to remain unaffected by conclusions reached by the original team.

In the original CiPPP research, a document audit form was developed to be completed by researchers assigned to various CHC sites. This form consisted of 43 yes/no questions, with opportunity for the auditor to elaborate. Upon reflection of the document audit questions, I determined the questions to be focused in five areas: 1) board structure and policy, 2) formal structures and documents, 3) volunteer participation, 4) organizational process and policies and 5) culture of participation (see Figure 3.2, Box 2). When I later examined the results and analysis of the original CiPPP data, it was clear the original research was much more comprehensive than I had captured in my design. Had I chosen to review the original CiPPP conclusions prior to the development of my study design, I may have categorized the document analysis questions differently.

In the original CiPPP research, CHC participants were asked to collect organization documents that were seen as key to the definition of the organization's culture and philosophy. These documents were either mailed to an auditor prior to arrival on site, or were picked up when the research team arrived at the CHC site.<sup>16</sup> A member of the CiPPP Research Team completed a document audit form for all but one of the 17 CHCs participating in the study. In this thesis, I used 14 audit forms because the data from two pilot sites was excluded and audit information was not completed on a third due to changing organization philosophy and management structure, making the existing documentation for this site irrelevant.<sup>73</sup>

In this document analysis, three processes took place to evaluate the content analysis in relation to citizen satisfaction with participation at each site and were described in Chapter 2 and earlier in this chapter. First, a literature review

established current knowledge of organizational development and citizen participation best practice. I also examined literature on organizational structures and processes that facilitate or obstruct participation. A literature search was done of elements of the chosen theoretical model to elaborate on the theoretical concepts of citizen participation within organizations (see Figure 3.2, Box 1).

### **3.3 Analysis Procedure**

The following sections describe the approach developed to analyze the audit forms for this thesis.

#### **3.3.1 Analysis of Tool**

The original CiPPP Audit Tool was examined and questions identified by theme as discussed in section 3.2.3.3. Questions were considered and fit into the Wiebe et al. model, using the conditions for participation ascertained from the literature review in Chapter Two (see Figures 2.4 and 2.5; Figure 3.2 Boxes 1 and 2).

Of the 14 completed audit forms, seven forms had gaps due to unanswered questions or questions answered with “unknown.” In the original CiPPP research, the analysis of audit forms was never intended to be an isolated exercise; the data was to be analyzed in concert with the survey and interview data. Further, there may have been no written information available to address these specific questions for these sites and the questions may have been answered elsewhere through the collection of data from group discussions or questionnaires.<sup>72</sup> However, the gaps in the audit forms resulted in inconclusive data and it became necessary to eliminate sites with significant gaps (discussed below).

#### **3.3.2 CHC Site Case Studies**

For this thesis, data analysis began with evaluating the data on each audit form as a whole (see Figure 3.2, Box 2a). Each audit form was first read in its entirety as a case study, in order to determine an overall sense of positive or negative



environment for citizen participation at that site. Case study questions included all 43 questions of the audit form (see Appendix 2).

I started the research process by subjectively examining the answers to the audit questionnaire for content. Audits were ranked as very low, low, low-moderate, moderate, moderate-high, high or very high regarding the participatory environment that might be nurtured by that element. For example, answers to the questions related to the Board were ranked higher if there was evidence of an active and participatory board membership, if the board was elected rather than appointed, if meeting minutes were easily attainable, and if responsibilities and structures were clearly laid out in documents. Answers to questions related to Formal Structures and Documents were ranked higher if there was a clear mission statement, if citizens and staff had opportunity to participate in the development of organizational documents, if interdisciplinary team work was supported in documents and if decision-making was shared with citizens and throughout the organization. Answers to questions related to volunteers ranked higher if there was strong evidence of volunteer presence and support in the organization's documents. Answers to questions related to Organizational Process and Policies ranked higher if there was evidence of community, volunteer and staff support in policies. Answers to questions related to Culture of Participation ranked higher if there was evidence of citizen participation built into key organizational documents and if the CHC showed evidence of community development efforts within the community. Figure 4.1 details the results of the case study analysis, and findings are detailed in Chapter 4.

### **3.3.3 Review by Critical Question**

Following the case study examination of the CHC document audit forms, a more detailed analysis was carried out in the form of a critical question analysis (see Figure 3.2, Box 2b) and is discussed in the findings of this thesis research in Chapter 4.

### **3.3.3.1 Critical Question Development**

In order to validate the analysis of the document audits as a case study, it was important to determine which questions from the document audit questionnaire were critical to the primary research question for this thesis. To do this, I identified a subset of document audit questions that were critical to my research question (see Figure 3.2, Box 2b; Appendix 2) by returning to the work done in the analysis of the data collection tool (see section 3.1 and Figure 3.2, Box 1 and 2). The following section describes how this was done.

In the original analysis of the document audit tool, the questions of the audit were contemplated in the context of my literature review and synthesis of elements within the Wiebe et al. model (the core organization and community factors which facilitate or obstruct citizen participation in health care decision-making)<sup>6</sup> (see Figure 2.4 and 2.5; Figure 3.2, Box 2). I then matched audit questions to one or more of the elements identified in the literature. Subsequently, the number of times a question applied to elements of the Wiebe model was counted. The matches of question to literature element ranged from 2 to 21 times. For example, one question appeared in the Wiebe model twice, while another question appeared in the Wiebe model 21 times.

I chose an inclusion rule of 11 or more correlations with the elements developed within the Wiebe et al. model<sup>6</sup> for audit questions to be included in the critical question analysis. Eighteen questions of the document audit questionnaire appeared 11 or more times (see Appendix 2 for audit tool and critical questions). Five questions were related to the Board, two were related to Formal Structures and Documents, three questions were related to Volunteers, seven to Organizational Processes and Policies, and one to Culture of Participation.

The central premise of this thesis is related to the organizational structures and processes which hinder or support citizen participation. It is, therefore, not

surprising that all the questions in the category “Organizational Processes and Policies” applied to at least 11 elements in the Wiebe model.<sup>6</sup>

It was surprising, however, that several of the questions related to the Board and to the Formal Structures and Documents did not appear enough times in the Wiebe model to be used as critical questions. Given the importance of organizational governance to the organizations’ structures and processes, I expected questions pertaining to the board to be more evident within the model. Similarly, an organization’s formal structures and documents are fundamental to formally recognizing and facilitating citizen participation within the organization and one would expect these to figure prominently in the critical questions as well.

Perhaps the nature of organizations and the nature of participatory work help to explain the absence of these questions in the Wiebe model.<sup>6</sup> The elements identified in the literature search and applied to the Wiebe model tend to be ‘soft skills,’ or those skills that are relational in nature such as development of mutual respect, listening, sharing of power and ownership of outcomes. Traditionally, these skills are not formalized in organizations’ official documents. It is not that these skills are undervalued; rather, the leadership of an organization may give these processes no particular thought in the development of formal documents as they may be assumed to be inherent in the process, or assumed to be imbedded in other processes and workings of the organization.

Some factors in the Wiebe model did not have any of the document audit questions that appeared to apply to them. The first is ‘legislation and political will’ under the domain of ‘Characteristics and Support of Participants.’ It may be surmised that lobbying and political activity on the part of health care organizations may not be overtly supported when the primary source of funding is directly or indirectly obtained from government bodies. Support and implementation of legislation may also be considered to be implied by the very nature of a health care organization. However, an organization’s political will is critical to the development and

enforcement of policy, such as recommitting funding dollars from acute care to prevention and health promotion, and to withstanding the tide of resistance in the event of enforcing legislation that may not be popular but is for the greater good, such as non-smoking workplaces and public space.

‘Research’ in the domain of ‘Characteristics of Setting – Organization Capacity’ also had no questions from the document audit that directly applied. This omission may be due to the fact that CHCs, with limited financial and human resources, commit energy and funds to front line service delivery rather than to research efforts and rely on larger, better-funded organizations for research development.

Upon review of the eliminated questions, questions 37, 39, 40, and 43 (see Appendix 2) were determined to be critical to the research question although they aligned with eight, nine or ten of the factors in the Wiebe model, not eleven or more as decided above. These questions refer either to specific formal structures of an organization (performance review, staff recognition and evaluation plans) which have intrinsic motivation for staff to facilitate citizen participation, or to specific processes and mechanisms of the organization (mechanisms to build values, part of a larger partnership) which indicate the value an organization places on establishing and promoting citizen participation through internal processes. The inclusion of these four questions brought the total number of critical questions to 22.

This re-examination of the data using just the critical questions was a way to validate the ranks assigned to CHCs in the case study audit review. Answers to the audit questions were again ranked as very low, low, low-moderate, moderate, moderate-high, high or very high as they were in the case study analysis (see Figure 4.1).

### **3.3.4 Inclusion Rule Development for Document Audits**

In order to ensure a minimum data set, it became necessary to establish an inclusion rule for the CHC document audit questionnaires. The audit documents were

reviewed and the number of questions answered with ‘unknown’ or left blank were considered non-answers. The questions were tallied and a percentage assigned based on the number of questions answered with a definitive yes or no. Some questions did not have a ‘yes’ or ‘no’ assigned but had elaborations in the accompanying narrative that indicated a definitive yes or no response. Based on these elaborations, I assigned some questions a ‘yes’ or ‘no.’ The number of audit documents with 80% or more of the case study questions answered was nine, including sites N, C, E, K, M, O, H, I and F (according to final rank from high to low). The number of audit documents with 80% or more of the critical questions answered was also nine, including sites N, C, E, K, M, O, H, G and L (according to final rank from high to low). Figure 4.1 details the percentage of case study questions answered and critical questions answered for each site.

The CHC sites in each of these instances are not the same due to question elimination in the critical question review. If several of the questions deemed not critical to the research question were not answered in the case study review, these would have been eliminated in the critical questions review and would have driven up the percentage of questions answered in the critical question analysis. For example, Site L had 72.1% of the case study questions answered yet 81.8% of the critical questions were answered. Conversely, Site F had 81.4% of the case study questions answered and 73.9% of the critical questions answered.

Eleven document audit review questionnaires had 80% or more of either the case study or the critical questions answered. Eight of these eleven document audit review questionnaires (sites N, C, E, K, M, O, H and G) achieved 75% or more of questions answered in both the case study review and the critical question review. The remaining three document audit review questionnaires (sites I, L and F) were data-poor in one of the domains of Board, Formal Structures and Documents, Volunteers, Organizational Processes and Policies, or Culture of Participation due to unanswered questions. Therefore, it was not possible to accurately judge what

kind of participatory environment existed at that CHC for that domain and an overall ranking was not assigned.

Deciding on a rule of exclusion for the CHC sites was challenging. To choose an exclusion rule of 80% or more questions answered in both the case study review and the critical question review left only seven sites for analysis. An exclusion rule of 75% or more in both the case study review and the critical question review left eight sites. To choose an exclusion rule of 75% or more in either the case study review or the critical question review left eleven sites, but as discussed above three of these sites had significant data gaps in one of the domains making an accurate comparison unwieldy and challenging.

Another option for analysis was to compare the sites twice, first according to case study analysis results then according to the critical question analysis results. Ten sites achieved 75% or more in the case study analysis, and nine sites achieved 75% or more in the critical questions analysis. These were not all the same CHC sites (see discussion above).

### **3.4 Interpretation of Data**

Establishing evidence to answer the question posed by this research required a methodology that would promote consistency across sites and comparability of results. Interpreting site data separately using different analysis procedures would have made it more challenging to align and compare results. Therefore, the data was interpreted on the eight sites that achieved 75% or more of questions answered in the document audit in both the case study review and the critical question review. This included sites N, C, E, K, M, O, H and G (ranked from high to low), and excludes sites I, L, D, F, P and J.

#### **3.4.1 Interpretation of Results – Overall Ranking**

In order to achieve consistency in the assignment of an overall rank to the case study analysis and the critical question analysis, I assigned a Likert scale value to

the quality statements I used to describe the participatory environment assessed for each CHC. The quality statement of ‘very low’ was assigned a Likert value of 1; ‘low’ was assigned a value of 2; ‘low-moderate’ was assigned a value of 3; ‘moderate’ was assigned a value of 4; ‘moderate-high’ was assigned a value of 5; ‘high’ was assigned a value of 6; and ‘very high’ was assigned a value of 7 (see table 3.3). The values corresponding to the quality statement assigned to each domain were averaged for each CHC site (see Figure 3.2, Conclusion A). The resulting overall average value was translated to an overall quality statement or overall rank for that CHC site.

Using this process, the overall rank results for seven of the eight sites was the same in the case study analysis and the critical question analysis.

Site C was the only site in which the overall rank differed from the case study analysis to the critical question analysis. The difference was one rank decreasing from ‘very high’ assigned in the case study to ‘high’ in the critical question review. This difference was due to a difference in the rankings I assigned to one domain, Culture of Participation, where the CHC site was assigned a value of ‘very high’ in the case study analysis and ‘high’ in the critical question analysis. Two questions with positive answers were eliminated in the critical question analysis, and the remaining questions had slightly less positive narrative in response to questions answered positively. The final Likert score for the case study of Site C was 6.6 and the score for the critical question analysis was 6.4. The rounding up of the Likert score for the case study analysis and the rounding down of the Likert score for the critical question analysis resulted in the difference in the overall ranking value. Consequently, the difference is negligible, and the overall rank of ‘high’ assigned to the critical question analysis will be the one used in the final evaluation.

### **3.4.2 CiPPP Quantitative Survey Data Analysis Results**

This section of the discussion will compare by CHC site the results of the document analysis carried out in this thesis and the quantitative survey results done by the original CiPPP researchers (see Figure 3.2, Box 3).

When the original CiPPP research was complete, a confidential report was sent to each participating CHC site documenting the results of the quantitative survey data collected at that site. The surveys were designed for seven participant groups, targeting the knowledge base of each, and included the board of directors, administrators, health professional staff, support staff, volunteers, clients and community partners. Each group was administered a unique survey consisting of between 52 and 129 survey questions, depending on the group. Question types included Likert scale, nominal, and open-ended and were organized in four categories: demographics, community capacity, organizational capacity, and outcomes.<sup>75</sup> ‘Demographics’ captured information on gender/age, perceived health status, education, employment status, and client status. ‘Community capacity’ captured information on local institutions, supportive resources, attitudes towards participation, volunteer activity, and sense of control. ‘Organizational capacity’ captured information on CHC roles, attitudes towards participation, opportunities for participation, participation, volunteer activity, sense of control, relationship with clients, cultural tolerance, opportunities and importance of participation, and internal structures. Finally, ‘outcomes’ captured information on sense of ownership, life changes, enhanced participation, community cohesiveness and improved programs/services.<sup>15</sup>

Figures 3.3 to 3.5 summarize the results of the Likert scale questions from the original CiPPP quantitative survey research for community capacity, organizational capacity and outcomes. Demographic factors are not considered in this analysis. Only the eight sites that achieved 75% in both the case study review and the critical question review in the audit of key documents are presented. See Appendix 3 for a summary of the questions used in this analysis according to each factor.



The original CiPPP research team provided summary reports to the individual CHC sites. In these reports, answers to the Likert scale questions were assigned values of 1 (strongly disagree) through 5 (strongly agree). Each question was worded in the positive, for example, 'I am satisfied with the amount of control I have over decisions that affect my life.' Therefore, it was possible to calculate an average of answers to all Likert scale questions for each factor at each site. An average of results from the surveys of each participant group was calculated for each factor in the tables below. The factor was then assigned a rank of negative (1 – 2), negative/neutral (2.1 – 2.5), neutral (2.6 – 3.5), neutral/positive (3.6 – 4) or positive (4.1 – 5). This value system is consistent with the language used in the reports to the individual CHC sites, and is roughly translatable to the low through high values used in the analysis of the document audit.

The values of the factors that were analyzed using open-ended and nominal type questions within the domain of community capacity, organizational capacity and outcomes were averaged and recorded. This step was done in order to compare an overall rank for each site based on the quantitative data to the overall rank assigned to each site based on the audit of key documents process (see Figure 3.2, Conclusion B). The overall rank assigned to each CHC is represented in figure 3.6.

Figures 3.3 to 3.5 summarize only those factors that were analyzed using Likert-style questions. The factors that were analyzed using nominal and open-ended questions are discussed in the summary for each site later in this chapter. These factors include four elements of community capacity (local institutions, supportive resources, attitudes towards participation and volunteer activity) and four elements of organizational capacity (CHC activities, attitudes towards participation, participation and volunteer activity).

Figure 3.3

Community Capacity Indicators: CiPPP Quantitative Survey Data Analysis

Community Capacity								
Factor	Site N	Site O	Site M	Site H	Site K	Site C	Site G	Site E
<b>Sense of Control</b>	3.8 Neutral - Positive	3.7 Neutral - Positive	3.7 Neutral - Positive	3.1 Neutral	3.6 Neutral - Positive	3.5 Neutral	3.5 Neutral	3.2 Neutral
<b>Community Capacity Rank</b>	<b>Neutral – Positive</b>	<b>Neutral – Positive</b>	<b>Neutral – Positive</b>	<b>Neutral</b>	<b>Neutral – Positive</b>	<b>Neutral</b>	<b>Neutral</b>	<b>Neutral</b>

Figure 3.4

## Organizational Capacity Indicators: CiPPP Quantitative Survey Data Analysis

<b>Organizational Capacity</b>								
<b>Factor</b>	<b>Site N</b>	<b>Site O</b>	<b>Site M</b>	<b>Site H</b>	<b>Site K</b>	<b>Site C</b>	<b>Site G</b>	<b>Site E</b>
<b>Relationship with the Community</b>	4.2 Positive	4.1 Positive	4.1 Neutral - Positive	4.3 Positive	4.0 Neutral - Positive	4.1 Positive	3.9 Neutral – Positive	3.4 Neutral
<b>Relationship with Clients</b>	4.0 Neutral – Positive	4.3 Positive	4.1 Positive	4.2 Positive	3.7 Neutral - Positive	4.0 Neutral - Positive	3.8 Neutral – Positive	3.5 Neutral
<b>Cultural Tolerance</b>	4.0 Neutral – Positive	3.9 Neutral – Positive	3.8 Neutral - Positive	3.8 Neutral - Positive	3.9 Neutral - Positive	3.9 Neutral - Positive	3.8 Neutral – Positive	3.5 Neutral
<b>Opportunities for and Importance of Participation</b>	4.1 Positive	4.0 Neutral – Positive	4.1 Positive	4.2 Positive	3.6 Neutral - Positive	4.2 Positive	3.9 Neutral - Positive	3.2 Neutral
<b>Sense of Control</b>	3.8 Neutral - Positive	3.7 Neutral – Positive	3.7 Neutral - Positive	3.1 Neutral	3.6 Neutral - Positive	3.5 Neutral	3.5 Neutral	3.2 Neutral
<b>Internal Structures And Processes</b>	3.7 Neutral - Positive	3.5 Neutral	3.7 Neutral - Positive	3.8 Neutral - Positive	3.6 Neutral - Positive	3.7 Neutral - Positive	3.7 Neutral – Positive	3.1 Neutral
<b>Organizational Capacity Rank</b>	<b>4</b> <b>Neutral –</b> <b>Positive</b>	<b>3.9</b> <b>Neutral –</b> <b>Positive</b>	<b>3.9</b> <b>Neutral -</b> <b>Positive</b>	<b>3.9</b> <b>Neutral –</b> <b>Positive</b>	<b>3.7</b> <b>Neutral –</b> <b>Positive</b>	<b>3.9</b> <b>Neutral –</b> <b>Positive</b>	<b>3.8</b> <b>Neutral -</b> <b>Positive</b>	<b>3.3</b> <b>Neutral</b>

Figure 3.5

## Outcome Indicators: CiPPP Quantitative Survey Data Analysis

<b>Outcomes</b>								
<b>Factor</b>	<b>Site N</b>	<b>Site O</b>	<b>Site M</b>	<b>Site H</b>	<b>Site K</b>	<b>Site C</b>	<b>Site G</b>	<b>Site E</b>
<b>Sense of Ownership</b>	4.3 Positive	3.8 Neutral – Positive	3.8 Neutral - Positive	4.1 Positive	3.9 Neutral - Positive	4.0 Neutral - Positive	3.8 Neutral – Positive	3 Neutral
<b>Life Changes</b>	4.0 Neutral – Positive	3.8 Neutral – Positive	3.5 Neutral	4.1 Positive	3.7 Neutral - Positive	3.7 Neutral - Positive	3.7 Neutral – Positive	3 Neutral
<b>Enhanced Participation</b>	3.8 Neutral – Positive	3.6 Neutral – Positive	3.7 Neutral - Positive	4.0 Neutral - Positive	3.6 Neutral - Positive	3.6 Neutral - Positive	3.4 Neutral	2.6 Neutral
<b>Community Cohesiveness</b>	3.9 Neutral – Positive	3.9 Neutral – Positive	3.9 Neutral - Positive	4.3 Positive	4.1 Positive	3.8 Neutral - Positive	3.7 Neutral – Positive	3.1 Neutral
<b>Improved programs and/or services</b>	4.1 Positive	4.3 Positive	4.1 Positive	4.2 Positive	4.0 Neutral - Positive	3.9 Neutral - Positive	3.9 Neutral – Positive	3.9 Neutral – Positive
<b>Outcomes Rank</b>	<b>4.0</b> <b>Neutral -</b> <b>Positive</b>	<b>3.9</b> <b>Neutral -</b> <b>Positive</b>	<b>3.8</b> <b>Neutral -</b> <b>Positive</b>	<b>4.1</b> <b>Positive</b>	<b>3.9</b> <b>Neutral -</b> <b>Positive</b>	<b>3.8</b> <b>Neutral -</b> <b>Positive</b>	<b>3.7</b> <b>Neutral -</b> <b>Positive</b>	<b>3.1</b> <b>Neutral</b>

Figure 3.6

## Overall Rank by CHC Site: Quantitative Survey Analysis

	Site N	Site O	Site M	Site H	Site K	Site C	Site G	Site E
<b>Community Capacity</b>	3.8 Neutral - Positive	3.7 Neutral - Positive	3.7 Neutral - Positive	3.1 Neutral	3.6 Neutral - Positive	3.5 Neutral	3.5 Neutral	3.2 Neutral
<b>Organizational Capacity</b>	4.0 Neutral – Positive	3.9 Neutral – Positive	3.9 Neutral – Positive	3.9 Neutral – Positive	3.7 Neutral – Positive	3.9 Neutral – Positive	3.8 Neutral - Positive	3.3 Neutral
<b>Outcomes</b>	4.0 Neutral - Positive	3.9 Neutral - Positive	3.8 Neutral - Positive	4.1 Positive	3.9 Neutral - Positive	3.8 Neutral - Positive	3.7 Neutral - Positive	3.1 Neutral
<b>OVERALL RANK</b>	<b>3.9</b> <b>Neutral – Positive</b>	<b>3.8</b> <b>Neutral – Positive</b>	<b>3.8</b> <b>Neutral – Positive</b>	<b>3.7</b> <b>Neutral – Positive</b>	<b>3.7</b> <b>Neutral – Positive</b>	<b>3.7</b> <b>Neutral – Positive</b>	<b>3.7</b> <b>Neutral - Positive</b>	<b>3.2</b> <b>Neutral</b>

When the quantitative data is distilled to one number for each site, the differences in overall rank for each site (with the exception of Site E) are so minute as to be almost negligible. While there were differences between the individual factors for each domain at each site, the overall rank for all sites except Site E came out as ‘neutral-positive.’ Clearly, much richness is lost when quantitative data is treated in this way, as the nuance and significance behind the numbers becomes almost meaningless. Areas where there is a significant difference in opinion between two or more of the participant groups gets lost in the process of compiling the data in this way. For example, at Site K, the question ‘The CHC recognizes the contribution of clients and community members to the organization’ scored 5 with the Community Partners group but only 2 with the Administrators group. These differences may be due to a difference in perception of the question, or in a difference in knowledge of the workings of the organization.

Despite this limitation, it was ultimately necessary to do a global comparison of the results from the quantitative survey to the results from the document audit process (see Figure 3.2, Conclusion C) and therefore these rankings were used. In the document audit process, the sites ranked from highest to lowest were site C, K, H, M, O, N, E and G. The quantitative data process ranked the ranked from highest to lowest as site N, O, M, H, K, C, G and E, with site O and M being of the same rank and site H, K, C and G of the same rank. The subtleties of findings at each site are discussed in Chapter 4, Findings.

### **3.5 Delimitations/Sources of Bias**

‘Bias’ is a construct most often applied to quantitative research, with resulting negative effect on validity and generalizability. It is prudent to take note of the CHC site and participant selection process, as well as the data collection and analysis techniques, as possible sources of bias in this qualitative research.

Many of the potential sources of bias in this research are a result of the participatory nature of the original CiPPP design. As discussed earlier, one purpose of participatory research processes is to build capacity within participating sites and leave behind a sustainable resource and therefore many of these potential sources of bias are not of particular concern. However, they are presented here for consideration.

### **3.5.1 Selection Bias**

Participant selection in the original CiPPP research was through self-selection and other non-random means. Self-selection is desirable in participatory research, however it introduces an element of selection bias that will affect generalizability of research results to non-participating CHC sites. Since one goal of participatory research is to facilitate development and leave participants in the research with a relevant and useable product to be applied locally, then generalizability is not necessarily a central concern to researchers. Aspects of selection bias present in this thesis are discussed below for consideration.

The enthusiasm to participate of the self-identified sites may be indicative of qualities that may not be generalizable to other sites, since these sites may be more open to scrutiny or feel their level of citizen participation is greater than most and feel unthreatened by study. Those sites identified by the funder or by an employer may have qualities which may not be generalizable, since the reason for identification by an external agency may be due to remarkable traits (either negative or positive) as determined by that agency.

Nonresponse bias (a subset of selection bias) can affect the generalizability of research results, since “people who do not respond in a study often differ from those who do in regard to many demographic, socio-economic, cultural, lifestyle, and medical characteristics.”<sup>76, p 204</sup> This can apply to the CHC site as an

organization, and to the individual clients, volunteers and employees within the sites who participated in the research.

Characteristics of the participants within each site may also be a source of bias. Two thirds of respondents in the client category were either not currently employed or retired,<sup>15</sup> which may introduce an element of bias in client participant self-selection and may influence issues identified and level of participation. It is unknown if this is representative of all clients who visit CHCs at the sites, or just those clients who took the time to complete the survey.

### **3.5.2 Information Bias**

Information bias can occur when “the means for obtaining information ... are inadequate so that as a result some of the information ... is incorrect.”<sup>76, p 206</sup> In the original CiPPP study, rigorous quantitative data collection tools were developed which would be appropriate for the data sources (volunteers, clients, administrators). Care and attention were given to address issues of content and context validity, as well as reliability.<sup>15</sup> Qualitative rigour was ensured in the same way, with the use of a standardized document review template and two reviewers assessing results.<sup>15</sup> Triangulation was incorporated through the use of a variety of data collection means (surveys, focus groups, document audit) that results in corroboration of evidence gathered by each method.<sup>74</sup>

As discussed above, documents from the various organizations were analyzed by more than one researcher. Inter-auditor consistency during the content analysis phase of the research may be an issue and may have an effect on reliability of the results.

Since each organization was given the liberty to define its own important documents, varying amounts and types of information were obtained from each



site. Some sites may attach value to many pieces of information, providing a broad picture of the organizational culture; others may have been more selective in the information provided to the CiPPP researchers. Again, this is an important aspect of participatory research as design and implementation of the instruments is contingent upon ongoing input from participants as partners in the research. However, the variety in data input may potentially have contributed to information bias.

In my examination of the original CiPPP research, original data was not utilized. This created a significant limitation for this thesis. I did not know what the original data contained, and my analysis was limited to an examination of the analysis of data done by other researchers. Therefore, a number of assumptions needed to be made related to what the original data contained, and are discussed in Chapter 4, in the discussion of Findings.

### **3.5.3 Anonymity**

I analyzed the document audit forms and supporting CHC site documents prior to reviewing the CiPPP findings. Therefore, anonymity of sites was maintained in the initial analysis of the research question. Comparison of this qualitative document analysis with the quantitative and qualitative findings of the CiPPP research occurred only after the first stage was complete. It was then determined which qualitative and quantitative site findings matched with which document audit data. Contact with the organization would have happened only if clarification was needed, and only through the primary investigator, Dr. John Church, to comply with ethics commitments. As the research progressed it became evident this would not be necessary.

#### **3.5.4 Personal Bias**

In any research it is important to examine potential biases, particularly personal bias. Personal attributes of the researcher, such as age, gender, experience and ethnic background may influence the development of the research evidence.<sup>67</sup>

It is difficult to comprehend the importance of building in methods of inclusion and empowerment when exclusion and powerlessness have not been part of one's life experiences. As a university-educated, white woman raised in a rural family with means, I examined this data from a worldview of relative privilege.

Professional bias may also influence the analysis of this data. Having worked in administration of community health centres, I have developed a strong belief in the importance of equity of health service delivery and the right of individuals to control themselves and their environment. I believe it is the responsibility of health care providers and organizations to support public participation and citizen empowerment in philosophy and in action. However, my own vested interest in structures and processes within organizations that support citizen participation may result in a tendency to observe positive or negative associations that may not exist in reality. In discussing validity issues in qualitative research, Glesne refers to the process of using field notes as an audit trail to track lessons learned during the research process.<sup>77</sup> An audit trail was used to address clarity and transparency in this research. Further, anonymity of the sites served in part as a check and balance for researcher bias.

#### **3.6 Ethical Considerations**

In the original Citizen Participation Partnership Project, ethics application was made to and granted by the ethics board of the University of Alberta and the University of Saskatchewan. In the original CiPPP research, consent forms were signed prior to the distribution of surveys or participation in the focus groups.<sup>35</sup> A

new ethics application was made to the University of Saskatchewan Ethics Committee for the purpose of this research; the application was approved June 07, 2005 (see Appendix 1).

Respect for the intent of the original study was paramount to dissemination of the research information. The study sites signed informed consents for the purposes made clear through CiPPP. This consent was remembered throughout the analysis and will be a catalyst for dissemination of information to citizens and CHCs involved in the project, as well as for submission to scholarly journals for publication consideration.

### **3.7 Summary**

The various methodologies used in the original CiPPP research as well as the methodology used for this thesis research were described in this chapter. Real and potential limitations of this research were also presented in this chapter. These limitations were the result of the CiPPP and thesis study designs as well as personal and professional bias. The two research study methodologies with their limitations combine to produce the results of the qualitative secondary analysis of the CiPPP data, presented in Chapter Four.

## **Chapter Four**

### **Findings**

#### **4 FINDINGS**

The previous chapters documented the methodology and outcomes of the application of a research approach that took into account both community development philosophy and organizational development philosophy to the research question presented in this thesis. This question was, ‘what organizational behaviours and structures enable or obstruct citizen participation in organizational decision-making in community health centres?’ For some CHC sites, the results of the document audit process are similar to the results of the quantitative survey data analysis from the original CiPPP research, and quite different for sites.

In this chapter, I discuss the findings and their implications within the context of the expanded conceptual map by Wiebe et al. (see Figure 2.4 and 2.5). Examples to support these findings are given from the original CiPPP document analysis data.

Figure 4.1 demonstrates the results of the data evaluation for both the case study analysis and the critical question review. The table is interpreted in the sections to follow.

Figure 4.1

Ranking of CHC Site According to Participatory Environment: Case Study Review and Critical Questions Compared

CHC Site	Analysis Stage (Percent Questions Answered)	Domain and Rank (Corresponding Likert Value)					
		Board	Formal Structures and Documents	Volunteers	Organizational Process and Policies	Culture of Participation	OVERALL RANKING
Site C	Case Study (95.3%)	High (6)	High (6)	Very High (7)	Very High (7)	Very High (7)	Very High (6.6)
	Critical Question (100%)	High (6)	High (6)	Very High (7)	Very High (7)	High (6)	High (6.4)
Site H	Case Study (97.7%)	High (6)	High (6)	Moderate (4)	High (6)	High (6)	High (5.6)
	Critical Question (95.5%)	High (6)	Moderate – High (5)	High (6)	High (6)	Moderate – High (5)	High (5.6)
Site K	Case Study (100%)	Moderate – High (5)	High (6)	High (6)	High (6)	Moderate – High (5)	High (5.6)
	Critical Question (100%)	High (6)	Moderate – High (5)	High (6)	High (6)	Moderate – High (5)	High (5.6)

Figure 4.1 Continued

CHC Site	Analysis Stage (Percent Questions Answered)	Domain and Rank (Corresponding Likert Value)					
		Board	Formal Structures and Documents	Volunteers	Organizational Process and Policies	Culture of Participation	OVERALL RANKING
Site M	Case Study (97.7%)	Low – Moderate (3)	High (6)	Moderate – High (5)	High (6)	Moderate – High (5)	Moderate – High (5)
	Critical Question (100%)	Low (2)	High (6)	High (6)	High (6)	Moderate – High (5)	Moderate – High (5)
Site N	Case Study (88.4%)	High (6)	High (6)	Moderate (4)	High (6)	Moderate (4)	Moderate – High (5.2)
	Critical Question (86.4%)	High (6)	Moderate – High (5)	Moderate – High (5)	High (6)	Moderate – High (5)	Moderate – High (5.4)
Site O	Case Study (100%)	Low – Moderate (3)	Moderate (4)	High (6)	High (6)	High (6)	Moderate – High (5)
	Critical Question (100%)	Moderate – High (5)	Moderate (4)	Very High (7)	High (6)	Moderate (4)	Moderate – High (5.2)

Figure 4.1 Continued

CHC Site	Analysis Stage (Percent Questions Answered)	Domain and Rank (Corresponding Likert Value)					
		Board	Formal Structures and Documents	Volunteers	Organizational Process and Policies	Culture of Participation	OVERALL RANKING
Site E	Case Study (97.7%)	Moderate (4)	Moderate – High (5)	Moderate (4)	High (6)	Low (2)	<b>Moderate (4.2)</b>
	Critical Question (100%)	High (6)	Moderate (4)	Moderate (4)	High (6)	Low (2)	<b>Moderate (4.4)</b>
Site G	Case Study (76.7%)	Moderate (4)	Low – moderate (3)	Low (2)	Moderate (4)	Moderate (4)	<b>Low – Moderate (3.4)</b>
	Critical Question (81.8%)	Moderate (4)	Low (2)	Low (2)	Moderate (4)	Low – Moderate (3)	<b>Low – Moderate (3)</b>
Site L	Case Study (72.1%)	Low – Moderate (3)	High (6)	High (6)	High (6)	(unable to evaluate)	<b>Unable to evaluate</b>
	Critical Question (81.8%)	Moderate (4)	High (6)	High (6)	High (6)	Moderate – High (5)	<b>Moderate – High (5.4)</b>

Figure 4.1 Continued

CHC Site	Analysis Stage (Percent Questions Answered)	Domain and Rank (Corresponding Likert Value)					
		Board	Formal Structures and Documents	Volunteers	Organizational Process and Policies	Culture of Participation	OVERALL RANKING
Site F	Case Study (81.4%)	Low – Moderate (3)	Moderate (4)	High (6)	Moderate (4)	Low – Moderate (3)	Moderate (4)
	Critical Question (73.9%)	Moderate – High (5)	High (6)	High (6)	Moderate (4)	(unable to evaluate)	Unable to evaluate
Site I	Case Study (81.4%)	Low – Moderate (3)	Moderate – High (5)	Low (2)	Low (2)	Low (2)	Low – Moderate (2.8)
	Critical Question (63.6%)	(unable to evaluate)	Moderate (4)	Low (2)	Low (2)	Low (2)	Unable to evaluate
Site D	Case Study (69.8%)	High (6)	Moderate (4)	Moderate (4)	Moderate (4)	(unable to evaluate)	Unable to evaluate
	Critical Question (68.2%)	High (6)	Low – Moderate (3)	Moderate (4)	Moderate (4)	(unable to evaluate)	Unable to evaluate



Figure 4.1 Continued

CHC Site	Analysis Stage (Percent Questions Answered)	Domain and Rank (Corresponding Likert Value)					
		Board	Formal Structures and Documents	Volunteers	Organizational Process and Policies	Culture of Participation	OVERALL RANKING
Site J	Case Study (11.6%)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	Unable to evaluate
	Critical Question (4.5%)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	Unable to evaluate
Site P	Case Study (48.8%)	Low – Moderate (3)	Moderate (4)	(unable to evaluate)	(unable to evaluate)	(unable to evaluate)	Unable to evaluate
	Critical Question (31.8%)	Moderate (4)	Moderate (4)	(unable to evaluate)	(unable to evaluate)	Moderate (4)	Unable to evaluate

#### **4.1 Data Results Discussion**

In the final technical report of the CiPPP research, some generalizations were made based on the quantitative data related to community capacity (local institutions, supportive resources, attitudes towards participation and volunteer activity). Participants in the original CiPPP survey felt that first, community advocacy groups, then neighbourhood associations, were important catalysts within the community to encourage citizens to participate in the CHC. They felt social clubs, provincial and federal political organizations and religious organizations had less influence. Citizens saw the greatest motivator to participate was to improve services, followed by a chance to effect social change. Less common reasons were that they had specialized knowledge and the time to volunteer. Interestingly, personal health was the least most common reason motivating citizens to participate. In the CiPPP technical report, a number of supports were identified as necessary for citizens to participate. These included time, education and information. Less common responses included money, transportation and babysitting.<sup>75</sup> This result may reflect the demographic of volunteers at CHCs studied, or it may be a consequence of CHCs which already provide the service and therefore did not rank high as a need. Volunteer activity outside the CHC was common.<sup>75</sup>

Generalizations were also made based on the quantitative data related to organizational capacity (CHC activities, attitudes towards participation, participation and volunteer activity). The greatest opportunities to participate in decision-making were viewed by citizens to be in the areas of community health issues, social advocacy and planning. Less common responses included evaluation, communication, implementation and policy making. Citizens saw the CHCs to be active in the areas of planning, advocacy on community issues and contact with public officials. Less common responses included representing the community, publishing a newsletter, petitioning and mobilizing around health issues.<sup>75</sup>

#### **4.1.1 Site Discussions**

The following section describes the results of the comparison between the two analysis processes carried out in this thesis (see Figure 3.2, Conclusion C).

Figure 4.2

Overall Rank: Document Analysis and CiPPP Quantitative Survey Analysis

	<b>Document Analysis Final Rank</b>	<b>CiPPP Quantitative Survey Analysis Final Rank</b>	<b>Comparison of Final Rank</b>
<b>Site C</b>	High	Neutral-Positive	Differs by one rank
<b>Site H</b>	High	Neutral-Positive	Differs by one rank
<b>Site K</b>	High	Neutral-Positive	Differs by one rank
<b>Site M</b>	Moderate-High	Neutral-Positive	Same
<b>Site N</b>	Moderate-High	Neutral-Positive	Same
<b>Site O</b>	Moderate-High	Neutral-Positive	Same
<b>Site E</b>	Moderate	Neutral	Same
<b>Site G</b>	Low-Moderate	Neutral-Positive	Differs by two ranks

##### **4.1.1.1 Site C**

In the analysis done in Chapter Three, Site C received the highest ranking of the CHCs analyzed and was ‘very high’ in the case study analysis and ‘high’ in the critical question analysis. In the quantitative data analysis, Site C came out much lower, with a ranking of a moderate neutral-positive. This would translate to a difference of about one rank.

Site C had a number of attributes that made it stand out in the document audit although the overall sense of control responses in the CiPPP survey data was only neutral. This difference may have been affected by a less positive response to the survey respondents' sense of influence over decisions affecting their community.<sup>78</sup>

The document audit process showed evidence of strong organizational capacity at Site C, and was reflected in a high neutral-positive overall score for this category. A strong mission and values statement for the Site included statements on diversity and rights of volunteers and staff. Abundant opportunities for volunteers exist with clear job descriptions, training and support. Community groups are made welcome at the CHC through written policy. Job descriptions include statements on community development and capacity building. In the survey data, opinions were less favourable about the CHC's ability to cultivate leaders from culturally diverse backgrounds and this result may have affected the overall ranking.<sup>78</sup>

The outcomes category for Site C was also strong in the survey data. However, participants did not agree that all segments of the community were represented in decision-making. Opinions were neutral related to elements of community cohesiveness such as levels of trust.<sup>78</sup>

#### **4.1.1.2 Site H**

Site H ranked third in the document audit process, receiving an overall rank of high. In the survey data analysis, this site received a rank of neutral-positive. This is a difference of about one rank.

Organizational capacity was shown to be strong in the survey data analysis. Participants responded favourably regarding the CHC's relationship with the community and its clients. Cultural tolerance was also seen as a strength. Interestingly, responses by community partners indicated a higher degree of interest in being involved in the CHC than the responses of volunteers. Volunteers showed

a greater interest in being involved in governance at the CHC.<sup>79</sup> The document audit process for Site H demonstrated a process for volunteers to participate on an advisory committee and other governance committees at the CHC. Further, the CHC is directed by a community advisory council which may account for the greater degree of interest shown in governance by volunteers.

Community cohesion was seen to be a positive outcome of the activities of the CHC.<sup>79</sup> This result is supported by the document audit form in the yes/no answers, but there are few elaborations to describe why or how.

#### **4.1.1.3 Site K**

Site K received a ranking of high in the document audit process, and a moderate neutral-positive rank in the survey data analysis. This is a difference of about one rank.

In the community capacity category, survey participants responded in various ways to their sense of control in their lives, in the CHC and in the community. The groups were fairly positive about their control over decisions affecting their lives. Unlike results at other sites, board member respondents at Site K also felt quite positive about their influence on decisions affecting both the CHC and their community. However, clients were neutral about their influence on control in their lives, in the CHC and in the community.<sup>80</sup>

Responses to questions around relationships with the community and clients in the organizational capacity category were varied. Some groups felt positively in each of these categories and others felt less positively.<sup>80</sup> In the document audit process, there is conflicting evidence of the adequacy of communication and outreach. For example, board minutes are not readily accessible and there has not been an assessment of the community's health needs and resources. However, agency and community interaction is assessed in performance evaluations.

#### **4.1.1.4 Site M**

In the document audit process, Site M ranked at moderate-high. In the survey data results, this site achieved a high neutral-positive score or roughly the same.

Responses to all factors were positive overall. In the organizational capacity category, volunteers expressed little desire to participate in anything but meetings. Opportunities to participate were seen to be plentiful.<sup>81</sup> This finding is supported by the document audit which shows participation is built into various job descriptions and policies are very supportive of participation. However, the document audit process revealed a weak board structure.

The survey data analysis indicated Site M is weaker in the areas of communication with the community and proactivity in raising issues. Further, most participant groups were neutral about whether all segments of the community were represented in decision-making.<sup>81</sup>

#### **4.1.1.5 Site N**

In the document audit analysis done earlier in this chapter, Site N was ranked sixth out of the eight sites, with an overall rank of moderate-high. The analysis of the quantitative survey data indicates Site N is the CHC site with the greatest degree of citizen satisfaction, however the overall score was only neutral-positive. The results of the two processes are roughly the same.

Community capacity factors were all relatively positive, resulting in a higher neutral-positive score. Organizational capacity factors were slightly higher yet. Participants were very positive about the opportunities for participation and the importance placed on citizen participation. Most participants gave very favourable assessments of the relationship Site N has with the community. One element that may have brought the overall score down was that participants were less than positive about the CHC's overall communication with the community as a whole.

Also, employees of the CHC did not agree that the CHC meets the needs of the community.<sup>82</sup>

Opinions related to community cohesiveness in the ‘outcomes’ category were quite varied. Volunteers did not agree the CHC had changed the community’s attitudes towards specific health issues; board members did.<sup>82</sup>

The nominal questions of the document audit form show support for these findings, however, it is difficult to evaluate the degree of support as there are no elaborations to the yes/no answers on the audit form.

#### **4.1.1.6 Site O**

Site O ranked fifth out of the eight sites in the document audit process, earning a rank of moderate-high. In the quantitative survey data, Site O scored the second highest rank of a high neutral-positive. These scores would be roughly the same.

As with other sites, participants at Site O had a fairly positive sense of control over decisions affecting their lives, but felt less positive about their influence on decisions affecting the community. This result is supported by the document audit form, which indicates a relatively high level of participation by volunteers and a primary health care team philosophy. Structures and policies support community participation.<sup>83</sup>

At this site, religious organizations were the most important influence on citizen participation and the least influential was neighbourhood associations. This finding is directly opposite to the general trend of all the sites and may be reflected by the fact that the CHC was founded and continues to be run by a specific religious sect.<sup>83</sup>

While the site scored high overall in organizational capacity, specific concerns were raised by the participants’ responses. Community partners responded less favourably to the statements about the CHC’s participation in their organizations.

Opinions were variable about processes to address issues with community members and clients. Finally, participants did not agree that the CHC provided opportunities for citizens to participate in policy making.<sup>83</sup> This response is not supported by the document audit, which indicates a relatively high level of support for citizen participation as well as community outreach. It may be that the philosophy outlined in the organizations' documents is not being communicated at the service delivery level.

One final discrepancy is evident between the document audit and the survey responses. The survey respondents agreed the CHC is sensitive to diversity,<sup>83</sup> however the document audit revealed the CHC does not support homosexuals, abortion or related activities, or extramarital sex.

#### **4.1.1.7 Site E**

Site E received a rank of moderate in the document audit analysis and a rank of neutral in the survey data analysis, or roughly the same.

Unlike other sites, respondents of the survey at Site E were generally neutral to negative about the support of local institutions to encourage participation in the CHC.<sup>84</sup> The document audit of this site revealed this CHC was governed by an appointed Board that is responsible for services across the entire health region in which the CHC was located. This fact may account for some of the negativity regarding the influence of local institutions.

The document audit for Site E revealed that the volunteer opportunities at this site are limited to one program (First Responders). This fact may account for the negative response by health professionals regarding opportunities for community members to participate in decision-making in the CHC. Relationships with the community and with clients were generally seen as positive, although the response was not as positive as at other CHC sites. Participants were neutral about whether citizens of different cultures would feel comfortable participating, and participants



did not agree that the CHC made efforts to cultivate leaders from diverse backgrounds or that structures and processes encourage participation by all participants.<sup>84</sup> There is mixed evidence supporting this finding in the document audit process. Board members are not representative of the population served by the CHC, and there is not a process to evaluate citizen participation. However, the audit states there are mechanisms to facilitate staff and volunteer involvement in the development and review of policies and procedures, and organizational resources have been allocated to support the incorporation of citizens' views into strategic and service planning review.

#### **4.1.1.8 Site G**

Site G received a rank of low-moderate in the document audit process, and a higher rank of neutral-positive in the survey data analysis. The document audit process revealed that this CHC does not use volunteers which negatively affected the rank given in the document audit. The difference in outcomes is therefore not surprising, and resulted in a difference of two ranks between the two processes.

In the category of community capacity, respondents to the survey were not very positive about the amount of control they have over decisions affecting their lives or their communities. Board members did feel satisfied with the control they have over decisions made by the CHC. In organizational capacity, there was an indication of participation in the CHC by people other than staff (board members participated on committees, community partners participated in program planning, service development and community education). Community partners expressed an interest in involvement in the governance of the CHC, indicating potential for volunteer development if the organization chose to move in that direction.<sup>85</sup> There is nothing in the document audit that either supports or hinders the development of a volunteer base and the expansion of citizen participation in the CHC.

The survey data analysis of outcomes indicates participants do not agree that all segments of the community are represented in decision-making.<sup>85</sup> This finding is

not surprising if the volunteer program at the CHC is not well developed. Further, the document audit revealed the Board is not representative of the neighbourhood and the Executive Director of the CHC is the 'centre of the organization' and delegates day-to-day activities. This point may be an indicator of a unilateral decision-making process. Finally, the respondents believed that citizen participation had improved the quality and access to CHC services, however responses were mixed regarding whether the CHC was responsive to the needs of the community.

#### **4.2 Interpretation of Results – Domains**

The eight CHCs included in the analysis are represented by 40 sets of value statements or ranks for the case study and critical question analysis within the five question domains of Figure 4.1. Of the 40 rank combinations, 15 sets of ranks differed by one rank grade from the case study to the critical question analysis. This small difference is not unexpected given the nature of the analysis. The elimination of questions in the critical question analysis could result in a concentration of more positive or negative questions, and therefore influence the overall quality of the domain.

Of the 40 rank combinations, three combinations differed by two ranks between the case study analysis and the critical question analysis. However, the overall ranking for each of these sites was the same for both the case study analysis and the critical question analysis as discussed later in this chapter. The agreement between the case study analysis and the critical question analysis demonstrates internal consistency between the two processes.

Site H differed by two ranks in the domain of Volunteers. In the case study analysis, a rank of 'moderate' was assigned because there were a number of questions not answered, or answered with 'unknown' in this domain. In the critical question analysis, these questions were eliminated. The answers to the remaining

questions indicated an environment of high participatory practice and a rank of 'high' was assigned.

Site O differed by two ranks in the domain of the Board. In the case study analysis, a rank of 'low – moderate' was assigned due to a number of reasons. The board sub-structures were found to be inactive and participation of board members was determined to be poor by the original CiPPP researchers. The responsibilities and structures were vague and general, and some basic responsibilities such as meeting minutes were inadequate. In the critical question analysis, many of these questions were eliminated. Only one of the remaining questions was answered in the negative and the narrative of the positive answers indicated an environment of moderate – high citizen participatory practice.

Site E also differed by two ranks in the domain of the Board. In the case study analysis, a rank of 'moderate' was assigned. It was determined through the narrative of the questions that the board was not obviously representative of the population the CHC served, and the board operations were not particularly transparent and open to general public scrutiny. Many of the remaining questions were positive, however, in that serving the needs of the population seemed to be high on the board's agenda through needs assessments and development of policy. As with site O, the questions with negative answers in the Board domain were eliminated in the critical question analysis for Site E. The answers to the remaining questions represented an environment of high citizen participatory practice.

#### **4.3 Interpretation of Results: Conceptual Model**

The following sections discuss the findings of the comparison of the document analysis process to the quantitative results of the original CiPPP research within the context of the Wiebe et. al conceptual model.

### **4.3.1 Characteristics of Setting**

The encompassing characteristic of the Wiebe model is that of setting; it is the context within which citizens participate in health care decision-making.<sup>6</sup> Many elements in the literature fit into this sphere and were broken down into five categories: organization capacity, power, social capital (including community capacity and organizational capacity), organizational development and behaviour, and culture (both organizational culture and culture of the community). See Figure 4.1 for a summary of the points to follow.

#### **4.3.1.1 Organizational Capacity**

From the literature review, characteristics of organizational capacity include research, team capacity (atmosphere of learning, horizontal integration with other agencies, communication between levels of bureaucracy and communities), and ‘on the ground’ application of participation and teamwork philosophy (written goals, objectives and strategic plan, method of measuring progress, and structures allowing organizations and communities to work together). I determined the questions in the original CiPPP quantitative survey ‘relationship with the community’ and ‘internal structures and processes’ represented these qualities. In the document audit, I felt these qualities were represented throughout all the areas therefore this quality is represented by the overall score I assigned to each site. Consequently, one would expect the overall rank in the document audit to roughly correspond with the rank for the organizational capacity indicators of ‘relationship with the community’ and ‘internal structures and processes’ from the quantitative survey data.

This expectation holds true only for Sites H, M and E. Reasons for this discrepancy might be that I inaccurately categorized document audit questions in the tool analysis of this research, or that CHC policy is not being supported and implemented at the CHC service delivery level.

While a link was not found between the presence of policy and the satisfaction of citizens in participation, there were examples of best practices in the document audits in the domain of organizational capacity. These included attention to team capacity, integration with other agencies and communication between organizational levels. Site H had organizational policy for service providers to work in interdisciplinary teams. Strong formalized processes for volunteer participation, such as an orientation program, job description, an assigned staff resource person, and a position dedicated to community outreach are also best practices, and were present at site M.

As discussed earlier, a question related to participation in accreditation in the document audit would have provided evidence of the organization's method of measuring progress in this category.

#### **4.3.1.2 Power**

Elements of power from the literature include mutual respect and equal partnership with citizens and sharing and distributing of power. These were measured in the quantitative survey in the areas of sense of control, relationship with the community and opportunities and importance of participation. In the document audit procedure, power was measured primarily by questions related to the Board and organizational process and policies.

It is difficult to make an association between the existence of these factors based on the results of the quantitative survey and the document audit, since the rank for each of these elements is widely varying. The original research was not designed to explicitly address the concept of power; in fact, the principal investigator of the original CiPPP research intentionally chose not to focus on power as there is significant existing literature on power in relationship to citizen participation.<sup>59</sup> However, because power figures predominantly in the literature and the research models, it will be addressed in the context of the chosen conceptual map for this thesis.

Power is a nebulous concept and it is not unexpected that results in each area are different. Due to the omnipresent nature of power, the concept of power can be considered to be represented by most of the categories of the document audit procedure. I identified questions 35 – 37 (see Appendix 2) in the document audit to be specifically related to power. Site M and O had positive answers for these questions and sites E and G had negative answers. The overall rank for sites M, O and G in the document analysis corresponded with the rank given for each site in the areas of sense of control, relationship with the community and opportunities and importance of participation. Therefore, it might be concluded that the formalization of power relationships in an organization's documents may contribute to actual sharing of power at the service delivery level.

Examples of best practices related to power from the two sites with positive responses, sites M and O, include the expectation for involvement of community members and interdisciplinary team involvement in strategic and service planning. Job descriptions that include a statement on client participation in decision-making and community empowerment is another example of a best practice from site O.

#### **4.3.1.3 Social Capital**

The literature lists social will and recognition of community social capital as important elements of social capital. Questions from the document audit process were concentrated in the areas of volunteers and organizational process and policies. In the quantitative survey, this area was represented by 'opportunities for and importance of participation.'

The rank assigned to 'opportunities and importance of participation for volunteers' and 'organizational processes and policies' corresponded for all sites except sites K and G. Therefore, it might be concluded that the recognition of organizational and community social capital in an organization's formal documents may contribute to greater opportunities for participation for citizens.

Examples of best practices from those sites with a positive relationship between the document audit and the quantitative survey include volunteer participation on board committees, target recruitment in geographic/cultural areas, and building capacity in the community by supporting community groups.

#### **4.3.1.4 Organizational Development and Behaviour**

The elements of this subgroup of characteristics of setting include developmental maturity of the organization, political will, resource allocation and development support, shared vision within the organization/shared goals for the community, and supportive organizational structure (evidenced by a commitment to the process and facilitation of development and meaningful citizen participation, stakeholder approach to service delivery, and support written into the organization's key documents).

Organizational development and behaviour is comprised significantly of the leadership and governance processes of an organization. In the document audit questionnaire, the elements of the Board, formal structures and documents, and organizational processes and policies best represent this category. In the quantitative survey, organizational development and behaviour is represented by relationship with the community, relationship with clients, internal structures and processes, community cohesiveness and improved programs and/or services.

Because there are so many elements of the two analysis processes to compare, it is most useful to choose document audit questions that specifically speak to the elements of leadership and governance (questions 4, 5 and 8). In considering questions 4, 5 and 8 from the Board category in the document audit tool, sites M, N, C, H and K were answered with positively and site O was answered negatively. Sites E and G were ambiguous. Comparing the rank for board to the rank for internal structures and processes reveals only sites K and O have any related ranks. Therefore, it cannot be said that elements of organizational development and

behaviour written into an organization's documents contribute to improved citizen participation in decision making at the service delivery level.

One possible reason for this discrepancy is the fact that some of the CHCs surveyed were regionally managed and some were stand-alone, as discussed in Chapter One. The differences between these two types of boards stems from the fact that regional board members usually have a multitude of health organizations that report to them, and boards for independent CHCs are responsible only for that site and may be more responsive to the community they serve. There may have been differences in the individual responses of board members and volunteers at each of these types of sites. In the original CiPPP research, Regional board members were not surveyed.<sup>59</sup> This fact may also account for the discrepancy in findings between organizational development and behaviour written into the organization's documents and any resulting influence on improved citizen participation in decision making at the service delivery level.

In the CiPPP technical report, adequate funding was specifically identified as an area with particular sensitivity for organizational development and behaviour. Often programs were funded through grants or special project commitments, and operating dollars were not consistent.<sup>75</sup> Episodic funding may contribute to a perception of time-limited programs. A consequence of this may be a lack of commitment to the program by staff, and may lead to staff turnover and lack of development of the program. Further, the uncertainty of episodic funding may result in programs and services that are constantly under threat of non-renewal, and committed staff are left trying to create ways to ensure continuous service delivery. Consequently, a program may never see its full potential. The CiPPP technical report sums it up thus: "...effective organizational leadership and joint decision-making at the program and service levels are keys to successful outcomes (and) failing to adequately resource individuals working at these levels may eventually weaken the ability of CHCs to respond to community needs."<sup>75, p 33</sup>



Examples of best practices from the sites for which there was a relationship between the document audit and the quantitative survey include actively involved board members whose responsibilities are listed in the organization's bylaws. Stability of the board also seemed to be an important factor. Since board members from Regionally run CHCs were not surveyed, it is unknown if these best practices were reflected in the Regionally run CHCs.

#### **4.3.1.5 Culture**

Traditionally, culture is associated with heritage, belief systems and ideology. Organizational culture is affected by these elements of culture, and has elements unique to it. These include attitude translation into policy, the community and the organization's prior experience with participation, and the holistic view an organization has of the community and its citizens. The CiPPP technical report discusses organizational culture as the ideological foundation of empowerment and a participative approach to decision making that blends the organization's culture, leadership, structures and processes.<sup>75</sup>

In the document audit, culture is represented by culture of participation and organizational process and policies. Culture is measured in the CiPPP quantitative survey in the areas of relationship with community and relationship with clients. In this context, culture does not include the category 'cultural tolerance' because this refers to heritage and belief systems of a distinct community group. In comparing the ranks for these categories at all sites, all but sites O and G correlate between the quantitative survey and the document audit process. Therefore it is possible to conclude that elements of culture formalized in an organization's documents may contribute to improved relationships between the organization and its community and clients.

Examples of best practices related to culture in the CHCs with a positive relationship between the document audit and the quantitative survey include having clients participate in staff performance reviews, involvement in strategic planning,

community use of CHC space, and community development as part of staff job descriptions.

The following sections discuss the inner spheres of the Wiebe model, including characteristics and support of participants, goals and objectives of participation, characteristics of participatory techniques, and characteristics of change.

#### **4.3.2 Characteristics and Support of Participants**

Elements of this sphere include legislation and political will, knowledge distribution, recognition of community social capital, and group process (group facilitation and governance). These elements were measured in the quantitative survey in the areas of opportunities for and importance of participation. In the document audit, these elements were represented in all the areas (board, formal structures and documents, volunteers, organizational process and policies and culture of participation).

Because the document audit questions related to characteristics and support of participants were throughout the audit, the overall rank for each site represents the site's score for this area. Therefore, one would expect the overall rank in the document audit to roughly correspond with the rank for opportunities and importance of participation. This holds true for Sites C, H, M, O and N, but not for Sites K, E and G. Overall, one might conclude the literature is supported by the evidence presented in this research for this component.

Examples of best practices for characteristics and support of participants include many of the best practices listed above, but perhaps most specifically those elements related to knowledge distribution and group process. These include thorough training and support of volunteers, participation of citizens on advisory committees, and formal policies on the rights of staff, volunteers and clients.

#### **4.3.3 Goals and Objectives of Participation**

Elements within this sphere include seeing participation as an outcome as well as a process, and accountability and transparency within the organization. These were addressed in the quantitative survey (opportunities for and importance of participation; enhanced participation) as well as in the document audit process (Board, organizational process and policies).

A basic assumption of this research is that statements and beliefs written in an organization's formal documents will translate to greater productivity or satisfaction in that area. We would expect to see CHCs with written commitment to participation in the document audit score higher in the areas of opportunities for and importance of participation, and enhanced participation. This expectation does seem to be the case for these categories. For example, Site O scored high in the process and policies category because it had significant and imaginative outreach policies and involved the communities and volunteers in many ways. Survey question responses were neutral to positive in the areas of opportunities for and importance of participation, and enhanced participation.

Board accountability to the community served was indicated as particularly important in the CiPPP final technical report of the quantitative survey results. However, the technical report also indicated that in some instances citizens believed a more important role of the board was to serve as a link to larger institutions and networks such as other health care organizations and government bodies.<sup>75</sup> At times, these two expectations or responsibilities may be incompatible due to conflicting pressures. For example, the time and energy of a board may easily be consumed by the demands of connecting with larger networks, and very little attention paid to the local needs of the CHC.

Best practices demonstrated by the CHCs related to this domain include those which increase organizational communication with and responsibility to citizens, as well as ownership taken on by citizens. Examples include formal and informal

communication processes including newsletters, invitations to board meetings and facilitating access to organizational documents such as meeting minutes.

#### **4.3.4 Characteristics of Participatory Techniques**

Elements of this sphere include recruitment to participation (including leadership), development of non-traditional ways to participate, and actively engaging and enabling groups to participate in a familiar environment. These were addressed in the quantitative survey (cultural tolerance, attitudes towards participation and relationship with community are a few examples) as well as in the document audit process (for example, culture of participation, board).

It is difficult to make a comparison between the existence of these factors based on the results of the quantitative survey and the document audit, since the rank for each of these elements and overall rank is widely varying. For example, site M scored high in relationship with community but lower in cultural tolerance, and was low in the board category of the document review and moderate to high in culture of participation. Therefore, it cannot be said that characteristics of participatory techniques written into an organization's documents contribute to improved citizen participation in decision making at the service delivery level.

Because no relationship was established in this domain between the document audit and the quantitative survey results, it is difficult to identify what best practices might lead to an increase in citizen participation as it relates to characteristics of participatory techniques.

#### **4.3.5 Characteristics of Change**

In the literature a systems thinking approach to change was considered best practice and is evidenced by a holistic view of the organization as a system, interconnectedness, and a state where the organization's structure influences its behaviour. Questions related to the formal structures and documents as well as organizational processes and policies in the document audit, and questions related

to internal structures and processes of the quantitative survey touched on these issues. Sites where connections were stronger to the community tended to score higher in both the survey and the document analysis ratings (for example, sites C, H). However, the final CiPPP report indicates volunteer activities are compartmentalized and often volunteers and staff are unaware of what is going on in other parts of the organization.<sup>75</sup> This finding may be indicative of “the extent to which participation is integrated as a line of business within the organization. It also (may) reflect the fact that volunteers at a number of sites were not clients, or were clients for specific programs (or) services.”<sup>59</sup> Insulation of programs and lack of knowledge of other services within organizations can lead to fragmentation and/or repetition of health services, or missed intervention opportunities, and is contrary to a holistic care approach.

Commitment to change and ownership of outcomes are also important to characteristics of change and were measured in the survey in the category of outcome indicators, and in the document review in the Board category. Sites that received high rankings in these areas did not translate to higher overall ranks in both the survey analysis and the document review (for example, sites H, M and N). Therefore, it cannot be said that a commitment to change written into an organization’s documents will be translated to ownership and teamwork at the service delivery level.

An example of systems thinking best practices found in the document audits of the CHC sites includes the formalization of an interdisciplinary health care team approach to the functioning of an organization.

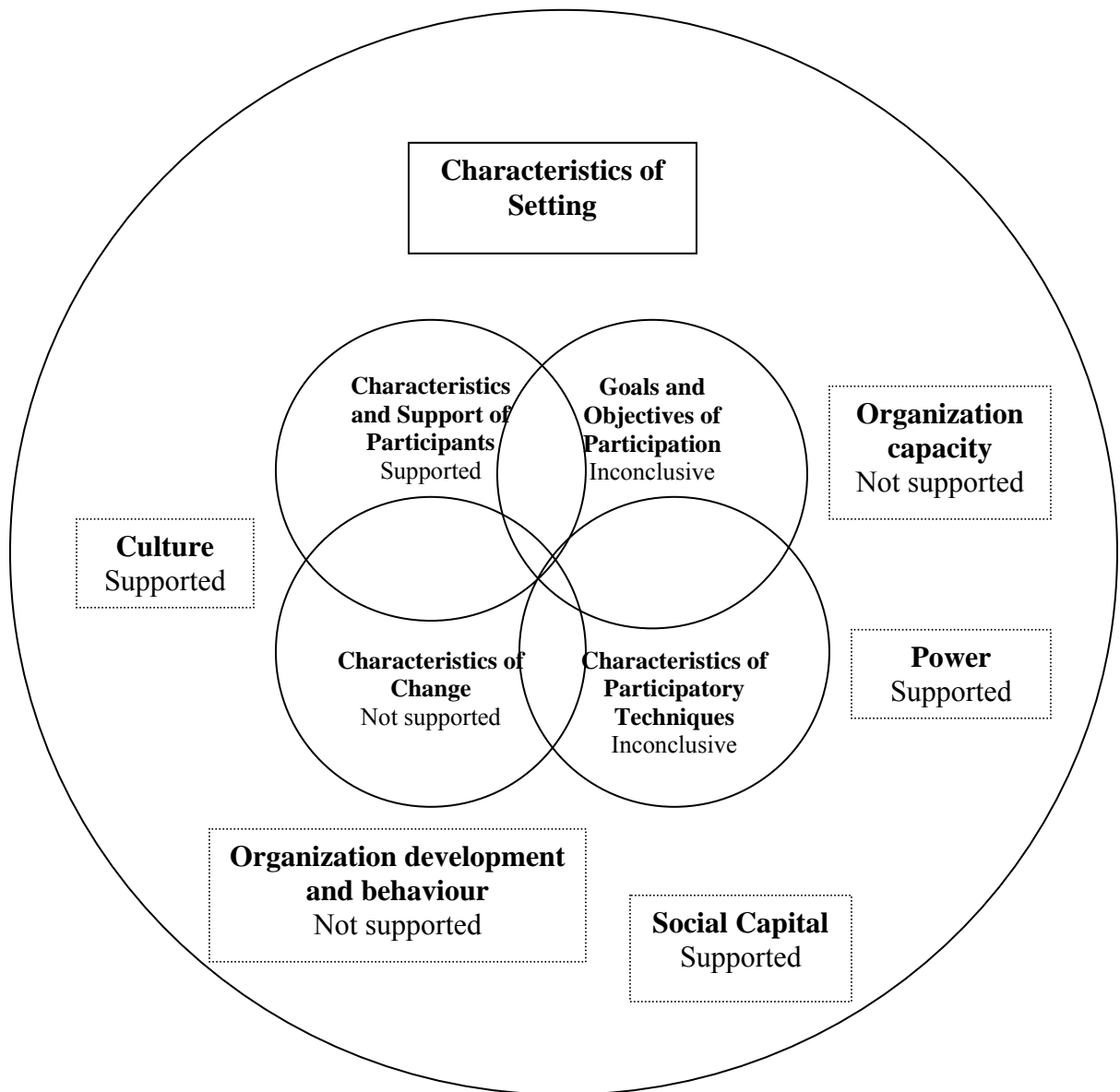
#### **4.4 Interpretation of Results**

Figure 4.3 below provides a visual summary of the conclusions of the comparison between the CiPPP quantitative data survey and the document audit reviews, within the context of each domain of the Wiebe et al. conceptual map.

The global domain of this model is ‘characteristics of setting.’ The results of this thesis research supported evidence in the literature related to the sub-categories of ‘culture,’ ‘power’ and ‘social capital,’ but did not support evidence in the literature related to the sub-categories of ‘organization development and behaviour’ and ‘organization capacity.’

The internal domains of the conceptual map include ‘goals and objectives of participation,’ ‘characteristics of participatory techniques,’ ‘characteristics of change,’ and ‘characteristics and support of participants.’ The results of this thesis research supported evidence in the literature related to the internal domain of ‘characteristics and support of participants.’ However, the internal domains of ‘goals and objectives of participation’ and ‘characteristics of participatory techniques,’ were inconclusive and the results of ‘characteristics of change’ did not support evidence in the literature. Possible explanations for these results are discussed in Chapter 5.

Figure 4.3  
Discussion of Site Results in the Context of the Wiebe Model



#### **4.5 Conclusions**

The research question for this thesis was: what organizational behaviours and structures enable or obstruct citizen participation in organizational decision-making in community health centres? The discussion of conclusions based on this research is set in the global context of how organizational development processes inform and

support community development processes, and from the perspective of the Wiebe et al. conceptual model.

A discussion of the conclusions of this research must begin with reflection upon the components of the conceptual model used to explore the elements of citizen participation, and how the components of the model are either supported or refuted by this research. The discussion in section 4.6 describes in detail how half of the elements of the Wiebe et al. model are supported in this research, and half are either inconclusive or not supported. A number of factors may contribute to the lack of conclusive support for the Wiebe et al. model as described above in section 4.6.1; however, ultimately it must be said that the Wiebe et al. model and the literature is neither supported nor refuted by the evidence presented in this research.

Based on this conclusion and what was learned from this research, a return to the conceptual model is necessary to determine whether it is still a useful model to describe citizen participation and if so, whether emphasis on certain components has changed within the context of this study.

It is inappropriate to conclude that based on this research, the Wiebe et al. model is not useful to describe citizen participation in all situations. Chapter 5 introduces possible factors which may have contributed to conclusions drawn in this research. However, within the context of this thesis, certain elements of the model become more influential than the rest.

The first component of the Wiebe model that appears to be more influential than the rest is the sub-components of ‘social capital’ within ‘characteristics of setting.’ This sub-category included the characteristics of recognition and removal of barriers to participation, acknowledgement and support of local knowledge, and skill development and values-based training. Perhaps a focus on these elements overcame negative influences of other elements and resulted in a positive environment for participation.



While the literature on ‘organization capacity’ and ‘organization development and behaviour’ was not supported by the evidence in this research, they are still important influences in organizational development. Several examples of best practices were evident in the document analysis, and it is difficult to say why the evidence is not congruent with the literature.

The central concept of ‘characteristics and support of participants’ also emerged as an important factor of the Wiebe et al. model within the context of this research. Elements of this component include knowledge distribution, recognition of community social capital, and facilitation of group process. A number of best practices were identified related to this concept from the document audit, and positive influences from this factor may have helped to overcome less positive influences from other factors.

A final reflection on the research question resulted in the conclusion that there are a multitude of organizational behaviours and structures which enable or obstruct citizen participation in organizational decision-making in community health centres. These organizational behaviours and structures are operationalized in a variety of ways, depending on the context and culture of the organization and the people with whom the organization interacts. Some of these behaviours are presented as examples of best practice, and some are presented in the recommendations in Chapter 5. Ultimately, it is clear I was unable to answer the research question originally crafted given the data used.

Upon reflection, a more appropriate question given the philosophical approach I have taken to this research, is: ‘are formal organizational values and policies operationalized at the service delivery level, into structures and processes that effectively achieve citizen participation in CHC decision-making?’ Based on the above discussion of research results, the answer to this question is inconclusive. This research shows that while organizations can have citizen participation

formalized in their official documents, this may or may not translate to meaningful and effective citizen participation in CHC decision-making. Further, the evidence of this research shows the reverse may also be true: organizations which do not have formal statements and policies which support citizen participation may still have an effective citizen decision-making influence. It would seem the influence of 'soft skills' and unwritten principles may be as influential as written policy, if not more so.

## **Chapter 5**

### **Discussion and Recommendations**

#### **5 DISCUSSION**

This chapter brings together the findings of this research with organizational best practices related to the facilitation of citizen participation in decision-making organization's governance and service delivery.

The findings presented in Chapter 4 are examined and discussed. Facilitating factors and barriers or challenges to participation are discussed using best practices found in the literature and the models presented earlier in this work, and within the larger context of community and organizational development, and primary health care philosophy. Finally, ideas for future research are explored.

#### **5.1 Discussion of Results: Document Audit and Survey Data**

The results of the document audit process are similar to the results of the survey data analysis for some sites and quite different for others. Possible reasons for this are explored here.

##### **5.1.1 Interpretation of Results: Document Audit Examination**

A number of researchers were assigned to complete the document audits at the various CHC sites in the CiPPP research. Analyzing the documentation from various sources proved challenging and a number of assumptions were made in interpreting the document audits which are documented below.

Through the document audit analysis, it became clear the document audit questionnaire was looking for information that may not be found in the formal documents of the organization because of the nature of the skills involved. Community development work is often done informally and the necessary skills result in relationship building, facilitating change and sharing power. It is difficult to ‘teach’ these skills; often they are the product of the worldview of individual professionals. It is also difficult to formalize these processes in an organization’s official documents. The leadership of an organization may assume these skills and processes are inherent to the primary health care philosophy and process, and not validate these skills and processes by formalizing them in official documents.

The analysis of the document audit questions required making assumptions based on the apparent values of the organization. For example, the audit question regarding involving volunteers in a variety of capacities led to the assumption that an organization had a deeper philosophy of citizen participation and that a variety of roles will result in volunteers who are more content with their participatory experience.

One of the potential sources of bias identified earlier in this work included personal bias. Because of my own experience in the development of CHCs in Saskatchewan RHAs, I found myself being critical of the answers to some of the audit questions. For example, Question 22 asks about the organization structure and process support of interdisciplinary team work, and described a scenario familiar to me. My experience has been that ‘co-location’ of professionals does not always translate into ‘teamwork’ and I was sceptical of the positive answers for some of the sites. This experience may have coloured my interpretation of the answers.

Question 32 asked if the CHC had “processes/structures in place to connect clients with appropriate person/program” (see Appendix 2). This question may be interpreted in two ways. First, it may be interpreted as service delivery in the primary health principle of ‘right person, right time, right place.’ For example, the

‘right’ professional sees the ‘right’ client at the ‘right’ time in the ‘right’ place through case conferencing, appropriate and timely referral, and advocating for the client with internal and external agencies. The second interpretation of this question is simple client triage. For example, a client presents to the CHC and a receptionist does a brief assessment and/or refers the client to the professional requested by the client. This approach is symptomatic of co-location of professionals and does not necessarily represent teamwork. If the question was interpreted as the latter, the deeper philosophy of primary health care teamwork is missed.

The answers to some questions were difficult to assess based on interpretation. For example, some auditors responded positively to Question 11, “Does the board communicate regularly with members?” with the elaboration that the board holds annual community meetings. Annual communication is indeed ‘regular’ but one might suggest it is neither optimal nor an example of best practice.

Discrepancies in the way researchers interpreted answers were noted. For example, for question 16, “policy on the rights of staff and volunteers,” one auditor answered in the affirmative and listed employees giving the oath of confidentiality as an example. Another auditor used this same example but answered in the negative.

### **5.1.2 Process**

At least two of the audits (Sites G and P) were conducted off-site. Consequently, the information in these audits is sketchy. It was challenging not to draw unsupported conclusions about some of the answers and make assumptions about the data and the workings of the CHC. For example, development of goals consistent with the community needs may not have been evident in the documents provided because, as a core value for CHCs, it could have been assumed this action would be done. The wording of some items in the documents provided may have led the document auditors to make assumptions.

In doing the case studies, several yes/no answers were left blank but based on the elaborations of that question, I assigned a 'yes' or 'no' answer which may not accurately reflect what the auditor found in the documentation. The organization may take for granted some processes as 'standard operating procedure' and these processes may not be documented in the information shared with the CiPPP research team. For example, the recording of meeting minutes is standard practice for most organizations and may not appear in an organization's formal documents.

Some audits were very thoroughly elaborated on, and as a result, it was easier in the case study analysis to be more critical of the level of service. The audit questions answered with a simple 'yes/no' left little to interpretation. It was easier in the case study analysis to be more critical of those document audits with more information.

### **5.1.3 Additional Information**

A question that may have deepened the information gleaned from the document audit is, 'Is management/leadership staff stable within the organization?' My experience is that staff turnover leads to lag time in program development and progress, and perhaps loss of faith by staff in the processes fundamental to a primary health care philosophy. This situation is particularly true when positions of key leadership turn over. This information would have deepened the information used in the evaluation of the research question presented in this thesis, because organizational structures and processes that support the organization's leadership lead to lower turnover of staff which, in turn, will possibly improve organizational development.

It may have been helpful to know if the CHCs participated in an external accreditation process (such as the Canadian Council of Health Services Accreditation), and any results. During the accreditation process, an organization's documents (among other things) are thoroughly examined by national peers and recommendations are made for improvement if necessary. Before, during, and after the accreditation process, citizens and staff work together to account for the

progress of the organization according to set standards and work on any recommendations made in previous accreditations. Accreditation is voluntary for Canadian health care organizations, and participation in the process indicates the organizations' official documents meet standards set nationally by professionals external to the organization.

## **5.2 Quantitative Survey Explanation of Results**

Possible sources of discrepancies in results that sprang from the quantitative survey data evaluation process were identified in the discussion of bias in Chapter Three (see Section 3.3.4). Elaborations and other possible sources are presented here.

Limitations of the CiPPP project were identified by the original research team and may have affected the data that was collected in the quantitative survey. There was little time to conduct validity tests on the data collection tool, and it was recommended in the technical report that if the study is replicated, construct validity studies should be performed. The project recruited widely varying numbers of participants at each CHC site, from a high of 169 to a low of 17 participants, which would have implications on generalizability. Last, the time frame for data collection was very brief and posed a problem for some CHCs given geographic location and number of staff available to participate in the data collection.<sup>75</sup> This last factor is also a possible explanation for the gaps in the document analysis data.

As introduced in Chapter Three, some meaning is lost in the distillation of the Likert scale data. The relatively homogeneous overall rankings of the sites do not accurately reflect the rich data obtained on each survey question for the individual CHCs. In the site discussions in Chapter Four, an attempt was made to highlight the significant differences where they existed between a CHC's overall rank and individual group responses.

Differences in responses between the groups of survey participants may be due to factors internal to the organization. Perceptions of employees of the CHC may be

quite different from those of volunteers and community partners because of their knowledge of the organization. For example, opportunities for citizen participation and participation in decision-making may be seen as plentiful by volunteers because they are not aware of the full scope of possibilities. Employees may see these possibilities as well as the barriers that prevent them from materializing and therefore answer related survey questions more negatively than volunteers.

It may have been interesting to further analyze the quantitative survey data using only the responses of the volunteers and board members and compare this to the document audit results. This comparison would have been more accurate, for it is the opinions of the citizens in whom we are most interested with this research related to citizen participation. However, this research is about the structures and processes of the organization, therefore the opinions of staff and community partners are both important for how the CHCs function on a global level, not just in relation to volunteers. Consequently, the responses of all participants were included in the analysis.

Interpretation of survey questions presents a possible source of discrepancy between the survey data and the document audit information. For example, volunteers may have no opportunity to participate in decision-making in the CHC but may also have no desire to do so. They may have indicated in the survey their satisfaction with their influence on decisions made by the CHC was high because they were not and did not want to be involved in decision-making within the organization. The researchers involved in the document audit process may have rated citizen participation in decision-making as ‘low’ if there was evidence that processes did not support this participation, making the assumption it was desirable.

### **5.3 Qualitative Data**

Focus groups and interviews were conducted with citizens, staff and volunteers at each of the CHC sites during the original data collection for the project. Issues measured by both the document audit process and the quantitative survey data



would most certainly be enriched by the qualitative data collected by these interviews. A separate analysis of the qualitative data for each site was not available at the time of writing of this thesis, and therefore was not included in the exploration of the research question presented in this thesis.

#### **5.4 Implications for Practice in Community Health Centres**

Implications for practice will be considered using the participation matrix presented in Chapter Two (see Figure 2.2). The matrix represents eighteen ways citizens can be involved in health care decision-making, including role perspectives as users or policy makers; making decisions on a global plane, at a local service delivery level or at the level of their individual treatments; and with a level of participation that ranges from simple consultation to complete control over the decision. As indicated earlier in this work, it can be anticipated that citizens' greatest participation and influence will be in the decision-making domain of service; the role perspective of policy; and the level of participation will realistically be partnership and perhaps consultation. There will always be a role for a citizen to participate in decision-making related to treatment as a user of the health care system, but the focus of this research is the effect of an organization's structure and process on citizen participation. Therefore, recommendations will focus on the areas of macro and service decision-making domain and policy role perspective.

##### **5.4.1 Participation Matrix: Decision-Making Dimension**

Recommendations based on this research are presented in the context of the participation matrix presented in Section 2.3.2. A summary of these recommendations is presented at the end of this section in Figure 5.1.

###### **5.4.1.1 Macro**

Citizen participation interventions at the macro level were not addressed in the scope of the CiPPP research. However, the role of legislation, political will, institutions of higher learning, and accountability of organizations to the

community they serve figured large in the literature reviewed in Chapter Two. These concepts are discussed earlier in this work.

#### **5.4.1.2 Service**

In the CiPPP technical report, Church recommends enhanced opportunities for citizens to participate ‘vertically and horizontally’ within an organization.<sup>75</sup> The connection of participation opportunities would result in a more holistic understanding of the organization and participation experience, and possibly enhance the decisions made by participants. Organizations must create stronger connections between existing programs and provide thorough orientations with volunteers that include all aspects of the organization. This recommendation is supported by this thesis research.

In the CiPPP technical report, Church cited confidentiality, safety, union and job requirements, and funding limitations or requirements as barriers to achieving enhanced participation opportunities throughout the organization. Therefore, a recommendation based on these findings might be to ensure labour unions and funding agencies are invited to participate in the development and ongoing maintenance of citizen participation programs. This recommendation is based on the results of the original CiPPP research.

A systems-thinking approach to change is achieved through a series of interrelationships rather than as a top-down, linear process. Results of the CiPPP project support this finding and recommendations include increasing the use of formal citizen and professional joint committees particularly in the area of policy and operational decision-making. This recommendation is based on the findings of the original CiPPP research and supported by the findings of this thesis research.

The document audit reviews as well as the quantitative survey both indicate that key communications primarily happen at the field level between the health care professional and the citizen. Regardless of the quality of an organization’s

documentation, it is this relationship upon which the success or failure of citizen participation relies. Understanding this relationship may help explain discrepancies between the document audit and the quantitative survey in the ranks assigned to some CHC sites. Therefore, organizations must pay more than lip service to facilitate health care professionals to develop and nurture these relationships. Encouraging relationship-building is not an easy thing for health care organizations to do given the financial constraints and outcomes-based atmospheres of most health care organizations. This finding is based on the original CiPPP research and supported by the findings of this thesis research.

In the CiPPP research, organizations exhibiting best practices were those which showed support of their community in several ways. The first was designated positions with a mandate to coordinate participatory opportunities, for example, community developers. The second was organizations which enhanced community capacity by providing office space and administrative support to community groups. Third, those organizations which acted as a catalyst or facilitator in the development of community action to address needs identified by the community.<sup>75</sup> A final example of best practice is the provision of support to volunteers through education. This recommendation is based on the findings of this thesis research.

Financial support in the form of transportation and babysitting were less important to respondents of the CiPPP research. This may be a consequence of the demographics of the respondents, or it may reflect the fact that some CHCs already provide the service and therefore did not rank as a need. Citizens need to ‘see themselves in the process’ to feel comfortable to participate, therefore the development of creative ways to engage under-represented groups such as single parents and minority groups is critical. For example, developing citizen participation groups that are operated out of a local cultural centre or a daycare will help to ensure marginalized citizens are given the opportunity to become involved in decision-making. This recommendation is based on the findings of the original CiPPP research.

## **5.4.2 Participation Matrix: Role Perspective**

### **5.4.2.1 Policy**

In the literature, the role of the CHC Board was cited as playing an important role in the development of a philosophy of citizen participation. However, the CiPPP research did not show a strong link between the role of the Board and the level of participation at a CHC. Further, this thesis did not demonstrate a strong link between the role of the Board and the satisfaction of citizens in their role at that CHC. The reasons for this might be related to the design of this study as discussed earlier in this thesis, or they might indeed be related to the function of the Board.

Recommendations and discussion from the CiPPP technical report describe a more favourable citizen participatory environment at the independent CHCs with Boards that are locally elected rather than the CHCs which are part of a larger regional structure with Boards which are more removed from the community. The CiPPP technical report explains that a locally elected Board may be less likely to be caught in larger political issues of the whole health region and other pressing needs such as acute care. These Boards also play a leadership role when a community experiences a crisis, and the CHC leadership is more sensitive to community needs. However, the technical report goes on to speculate if boards were such a crucial factor, there would have been a statistical difference in the quantitative data between the stand-alone and regional sites, which there was not.<sup>75</sup> This finding may also explain why there is less difference between the results of the sites in the survey data analysis than there was between the results in the document audit process, since in the document audit analysis, significant weight was placed on sites with highly functioning boards.

Whether the board is locally elected to manage just the CHC, or represents a larger health region governance structure, the board plays a fundamental leadership role for the organization. As described in the CiPPP technical report, solid leadership

and active membership of boards fosters several things within the organization and within the community. First, it enhances employee and client knowledge and belief in the leadership which, in turn, leads to greater satisfaction. It facilitates linkages between different levels of government and local organizations which will create an environment conducive to effective partnerships.<sup>75</sup> And finally, a board that is active within the organization will be knowledgeable about the multiple facets of the organization and therefore able to represent the organization fully and facilitate appropriate decisions. Therefore, a recommendation based on the findings of the CiPPP research as well as this thesis is that CHC boards must continue to be supported as fundamental structures of the organization, with a flat organization structure and board members who are active within the organization.

Funding to support citizen participation must be prioritized as a policy agenda item. Grant funding for community development work and positions are finite and often difficult to renew because they cannot demonstrate ‘success’ in the same way we are accustomed to in health care. Community development work takes years, if not decades, to realize fundamental change and ‘success’ cannot be proven in an evaluation of a program within a twelve-month funding cycle. Organizations must recognize the need and find a way to measure success in community development that is not driven by quantitatively measurable performance indicators. This recommendation is based on the original CiPPP research.

Finally, policy and program outcomes must be flexible enough to celebrate success, even if the success is not that which was defined by the organization’s professionals. Communities will find a way to meet the needs they identify, and these needs may not always reflect those priorities set by the organization. This recommendation is based on findings of the original CiPPP research and supported by evidence in the literature.

### **5.4.3 Participation Matrix: Level of Participation**

#### **5.4.3.1 Consultation to Partnership to Dominant**

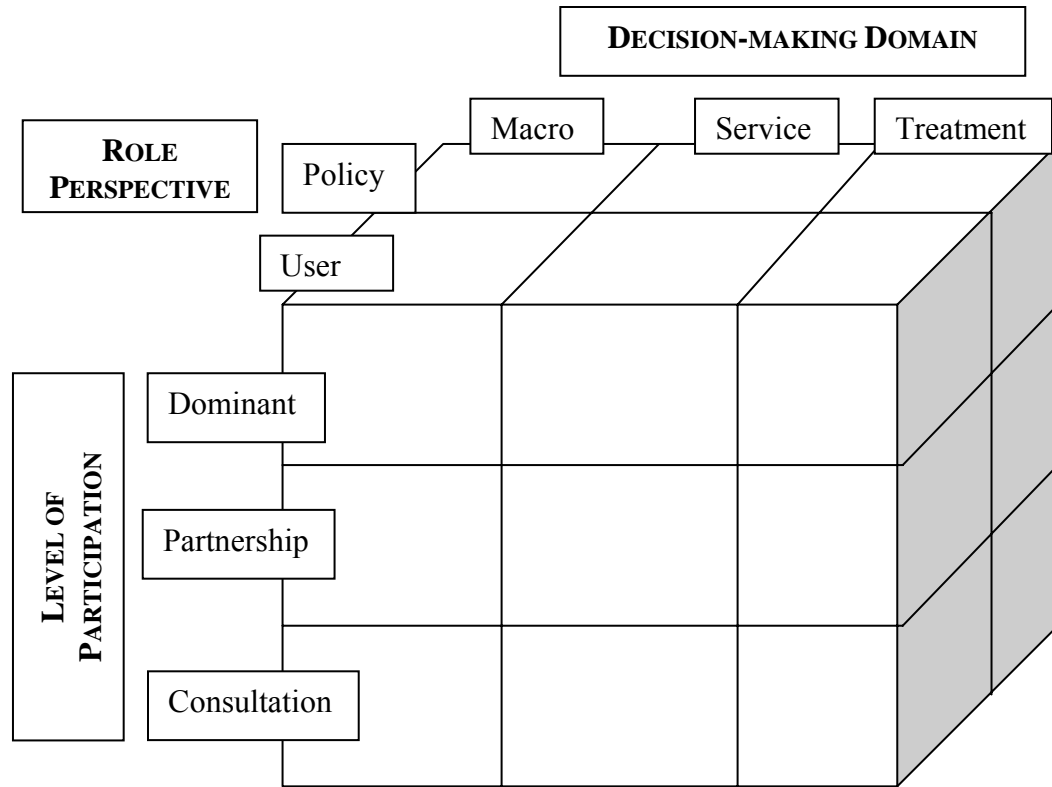
Two factors directly affect the level of decision-making participation that a citizen will experience within an organization. The first is power. The principle investigator of the original CiPPP research made a conscious decision to omit measures of power from the tools used in the CiPPP research, since it is so widely studied and much literature can be found regarding power. However, power is inherent to any human relationship and certain measures of power could be interpreted in some of the domains.

While the sharing of power was not easily measured in this research, it is clearly a significant unspoken dynamic. In order for power imbalance within organizations to change, organizations must put words to the force and then address it. Discussing power imbalances and their source, and working together with citizens to equalize the relationships is crucial to moving an organization forward to mutual respect and equal partnerships with citizens and other organizations. Part of the dynamic of power rests with the worldview of the health care professional, and an individual's fundamental belief regarding equity. Possibly training in the primary health care philosophy where students work together using a team approach to health care will help. This recommendation is based on findings of the original CiPPP research and supported by this thesis research.

Another factor that contributes to the degree of decision-making participation that a citizen will experience within an organization is professional capacity. It takes energy and resources to ensure citizens have opportunities to participate, and that they capitalize on those opportunities. But, most of all, it takes time. Given program-driven funding cycles, it is often impractical for professionals to ensure citizens are involved to the greatest degree possible, and participation is reduced to simple consultation. Therefore, appropriate funding and reasonable planning cycles

are necessary to engage citizens in a more participative way. This factor was not measured within the scope of this research so there is no formal recommendation.

Figure 5.1  
Discussion of Results – Participation Matrix



Domain	Element	Recommendations
Decision-making	Service	Creation of strong connections between existing programs of organizations in order to adopt a holistic approach to program and community development; provide thorough orientations for volunteers including all aspects of organizations.
	Organization/ Systems approach	Develop formal policy and operational decision-making relationships between citizens and professionals.



	Organization's relationship with citizens and community	Formal support of the community (for example, positions dedicated to community development, operating support of community groups, and acting as a facilitator in the development of community action).
<b>Role Perspective</b>	<b>Policy Leadership</b>	CHC boards are fundamental leadership structures and policy must support board members to be active within the organization.
	Measuring success	Policy statements formally support a long-term commitment to the process of community development.
<b>Level of Participation</b>	<b>Consultation to Partnership to Dominant Participation</b>	Development of a primary health care approach to service delivery, of which citizen participation is key.

### **5.5 Future Research**

The original CiPPP research was “designed to make a modest start”<sup>75, p 36</sup> in addressing the knowledge gap in how CHCs work to include citizens in decision-making at all levels. A number of areas for future research have become apparent as a result of conducting this analysis of the CiPPP data.

The next stage of analysis would be to compare the data examined here to the qualitative data collected in the CiPPP focus groups and interviews.

It would also be valuable to identify individuals who did not participate in the surveys to discover if there are any differences between non-responders and those who participated. Further, an attempt to identify and interview community members who are not participants in the CHC sites would provide a deeper perspective of this non-responder concept, and establish whether barriers exist to participation at the sites.

First Nations have a successful history of citizen participation in health care decision-making with the transfer of health care management from Health Canada to individual bands and Tribal Councils. Using a participatory research approach, it would be interesting to repeat this research with transferred First Nations to determine if the same concepts and theories hold true, and if there are other structures and processes that promote citizen participation not identified in this research.

A final recommendation for future research involves the connection between health care service delivery and business organizational development. The concepts of capacity building and empowerment are not new to business or to health care. The literature on these topics cites almost identical theories and concepts when researched from each perspective. It would be interesting to develop this research more fully using the theoretical approach of health care administration.

## **5.6 Conclusion**

This research demonstrated some association between support for citizen participation in an organization's documents and the ultimate satisfaction expressed by volunteers, health care professionals and citizens. While there are challenges to increasing citizen participation in the decision-making processes of organizations, there are benefits as well. A true test of the value of this research is if the CHC participants and readers can apply the recommendations to practice. Some recommendations are aimed at a political and social level beyond the scope of an individual CHC, but awareness of the need for change is the first step in the journey.

Public participation is a fundamental element of primary health care, and primary health care as a philosophy is a cornerstone of health care delivery in community health centres. "Success is achieved when citizen's views are weighed with the views of 'experts' and other stakeholders by those trusted to make a wise judgement or decision."<sup>5, p 17</sup> Perhaps it matters less if the citizens' point of view is

ultimately chosen as the way forward than it does that the citizen's opinion was considered with equal respect and consideration; a measure that can be integrated into all aspects of health care service delivery regardless of the organization's level of participatory evolution.

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**Appendix 1**  
**Ethics Approval**



**UNIVERSITY OF SASKATCHEWAN  
BEHAVIOURAL RESEARCH ETHICS BOARD**

<http://www.usask.ca/research/ethics.shtml>

**NAME:** Susan Wagner (Kate Thompson)  
Nursing

**Beh #05-126**

**DATE:** June 7, 2005

The University of Saskatchewan Behavioural Research Ethics Board has reviewed the Application for Ethics Approval for your research study "Impact of health organization structure and process on citizen participation in community health centre decision-making" (05-126).

1. Your study has been APPROVED.
2. Any significant changes to your proposed method, or your consent and recruitment procedures should be reported to the Chair for Research Ethics Board consideration in advance of its implementation.
3. The term of this approval is for 5 years.
4. This approval is valid for one year. A status report form must be submitted annually to the Chair of the Research Ethics Board in order to extend approval. This certificate will automatically be invalidated if a status report form is not received within one month of the anniversary date. Please refer to the website for further instructions <http://www.usask.ca/research/behavrsc.shtml>

I wish you a successful and informative study.

A handwritten signature in black ink, appearing to read "V. Thompson", written over a horizontal line.

Dr. Valerie Thompson, Chair  
University of Saskatchewan  
Behavioural Research Ethics Board

VT/cc

## Appendix 2

### CiPPP Document Audit Questionnaire

**Key:**

<b>Questions 1 – 17:</b>	Questions related to BOARD
<b>Questions 18 – 24:</b>	Questions related to FORMAL STRUCTURES AND DOCUMENTS
<b>Questions 25 – 29:</b>	Questions related to VOLUNTEERS
<b>Questions 30 – 35:</b>	Questions related to ORGANIZATIONAL PROCESS AND POLICIES
<b>Questions 36 – 43:</b>	Questions related to CULTURE OF PARTICIPATION
<b>Questions in bold:</b>	Questions included in Critical Question Analysis

1. Does the organization have a board of directors?

☐ Yes    ☐ No

Provide relevant details.

2. Is the board elected annually?

**3. Does the board have established structures/processes for nominating directors and appointing officers?**

4. Does the board have sub-structures (for example, committees or work groups – whether on-going or ad hoc) or other ways of organizing its work?

5. Are board responsibilities and structures clearly defined and communicated?

6. Are minutes kept of all board and committee meetings?

7. Are minutes readily accessible to all staff, community members and other stakeholders?

8. Is the board stable – That is, do the vast majority of directors attend board meetings and participate in board activities?

9. Does the board have continuity, i.e., a proportion of veteran as well as new members?
10. Does the board hold annual general meetings?
- 11. Does the board communicate regularly with members of the corporation?**
12. Is appropriate access to the board or its members by staff clearly outlined?
13. Does the board use appropriate channels of communication with the staff?
- 14. Does the board conduct regular (one-three year) assessments of the community's health needs and resources?**
15. Does the board have a policy or process regarding reporting citizen concerns/complaints?
- 16. Has the board approved a policy on the rights of staff, volunteers and clients?**

If yes to Question 16

- 17. Are staff, volunteers and clients informed of these rights?**
18. Does the centre have a clear statement of beliefs and principles?
- 19. Are the centre's beliefs and principles, goals and values developed through a process that involved the:**
  - centre's board ☐ Yes ☐ No
  - staff ☐ Yes ☐ No
  - volunteers ☐ Yes ☐ No
  - wider community ☐ Yes ☐ No

**Provide relevant details.**

20. Do the community health center's beliefs and principles recognize diversity in the community or communities it serves?
21. Do the organizational structure and processes support the CHC's values?
22. Do the organizational structure and processes support interdisciplinary team work and communications?
23. Is responsibility and authority delegated throughout the organization?
- 24. Has the CHC created formal and informal processes and forums to involve citizens in making decisions?**
- 25. Does the CHC involve volunteers in a variety of capacities?**
26. Are there mechanisms to facilitate staff and volunteer involvement in the development and review of policies and procedures that affect their roles?
- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Staff      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Volunteers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
- 27. Does the CHC have a structured program for volunteer recruitment, training and recognition?**
28. Are volunteers working in non-board roles oriented to their jobs or otherwise familiar with their job descriptions?
- 29. Is responsibility for volunteer supervision and support clearly assigned?**
- 30. Are there mechanisms in place to review policies and practices periodically and to allow staff and volunteers to raise concerns or have input into changes that affect them?**
- |            |                              |                             |
|------------|------------------------------|-----------------------------|
| Staff      | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Volunteers | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

- 31. Do the policies and practices promote the employment of a workforce which is responsive to the needs of the community served by the CHC?**
- 32. Does the CHC have processes/structures in place to greet clients, visitors, and community members in order to connect them with the appropriate person or program as quickly as possible?**
- 33. Do CHC structures and processes support community groups (space, staff work plans, job descriptions, facilitation, leadership development)?**
- 34. Are staff education programs in place to support the implementation and maintenance of these consumer policies?**
- 35. Have organizational resources been allocated to support the incorporation of citizens' views into strategic and service planning and review?**
- 36. Is citizen participation incorporated into job and position specifications?**
- 37. Are citizen participation efforts and achievements incorporated into performance management and staff recognition processes?**
- 38. Does the organization make special efforts to cultivate leaders from culturally diverse backgrounds?**
- 39. Does the CHC use mechanisms to build shared values across the community?**
- 40. Does the CHC have a citizen participation evaluation plan in place?**
- 41. Are board members representative of the makeup of the neighbourhood/ population served?**
- 42. Do they live and/or work in the neighbourhood?**

Live in ☐ Yes ☐ No  
Work in ☐ Yes ☐ No

**43. Is the organization part of a larger neighbourhood organization, partnership, or coordinating body that deals with health and social issues?**



**Appendix 3**  
**Quantitative Survey Questions Used in Data Analysis**

<b>Community Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
<b>Local Institutions</b>	The following things in the CHCs community encourage people to participate in the CHC (presence of religious organizations, presence of provincial/federal political organizations, presence of strong municipal political representation, presence of other community advocacy groups, presence of neighbourhood association, presence of social clubs)
<b>Supportive Resources</b>	<p>If you were to work with the CHC on these issues, would you need any of the following supports in order to do so? (time to do it, money to cover personal expenses, transportation, babysitting, information, education or training)</p> <p>Which of these supports do you find most important? (time, money, transportation, information, education or training, multiple answers)</p> <p>I am motivated to participate in the CHC because I have (time to do it, special knowledge/skills, personal health issue, a desire to improve services in this community, a desire to influence larger social change)</p> <p>The following resources are necessary to make me feel it is worthwhile to participate in the CHC (time, money, transportation, babysitting, information, education, expertise)</p>
<b>Attitudes Towards Participation</b>	What would motivate you to work with the CHC? (personal health issue, family health issue, a desire to improve health and social wellbeing in this community, a desire to influence large social change)
<b>Volunteer Activity</b>	<p>Do you work as a volunteer with other organizations?</p> <p>Do you hold a publicly elected/appointed office?</p> <p>I belong to the following (community advocacy groups, community association, social clubs, religious organizations provincial/federal political organizations, professional association, service organizations)</p> <p>On average, how many hours per month do you spend on</p>

<b>Community Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
	<p>these voluntary activities outside the CHC?</p> <p>About how many hours per month do you spend on Centre business?</p>
<b>Sense of Control</b>	<p>I am satisfied with the amount of control I have over decisions that affect my life.</p> <p>I am satisfied with the amount of influence I have over decisions that affect my community.</p> <p>I am satisfied with the amount of influence I have over decisions that this CHC makes.</p> <p>The community knows what CHC resources are available to address an issue.</p> <p>My community has influence over the decisions that affect my life.</p> <p>I am satisfied with the amount of influence my organization has over decisions that this CHC makes.</p> <p>I am satisfied with the amount of influence my organization has over decisions that affect my community.</p>

<b>Organizational Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
<b>CHC Activities</b>	<p>The CHC does the following: (plan a community program, develop and deliver a service, educate the community on an issue, publish a community newsletter, publish brochures and pamphlets, represent the community in public forums, talk to government about community issues, organize for group action, mobilize a protest demonstration, petition, contact public officials about community needs, advocate for individual clients, advocate on community issues, form alliances to address issues).</p>
<b>Relationship with the Community</b>	<p>The CHC knows what community resources are available to address an issue.</p> <p>The CHC has clearly identified who their community is.</p> <p>This CHC can influence decisions that affect its community</p>

<b>Organizational Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
	<p>The CHC is supportive of other community groups.</p> <p>The CHC works with other organizations in assessing community health status and community needs.</p> <p>The CHC has acted as a catalyst for bringing members of the community together to discuss common health/social issues.</p> <p>The CHC makes it easy for may organization to participate in decisions about community health and social issues.</p> <p>The CHC facilitates your organizations' involvement in the development, delivery and evaluation of programs and services.</p> <p>The CHC advocates for its individual clients with other service providers in the community.</p> <p>The CHC communicates effectively with other partner organizations in the community.</p> <p>The CHC communicates effectively with the community as a whole.</p>
<b>Relationship with Clients</b>	<p>Links are in place among service in the CHC and outside community/support groups to ensure client satisfaction with continuity of care.</p> <p>The CHC has well-established links with decision-makers and opinion leaders in the community.</p> <p>The CHC is proactive, raising issues that anticipate change in the environment in which the Centre operates.</p> <p>The CHC is aware of the key client and community members' issues.</p> <p>The CHC has processes in place to jointly address these issues with clients and community members.</p> <p>The CHC has a welcoming intake system.</p> <p>Links are in place among services within the CHC to ensure client satisfaction with continuity of care.</p> <p>The CHC provides education, training, and information in a form that supports the client in making decisions.</p> <p>The CHC works with the client to improve the client's</p>

<b>Organizational Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
	<p>ability to respond to identified health issues.</p> <p>The CHC makes it easy for me to participate in decisions about my health.</p> <p>Clients are encouraged and supported to be full and equal participants in decision-making about what actions are appropriate for them to maintain or enhance their health.</p>
<b>Cultural Tolerance</b>	<p>People of different cultures feel comfortable sharing their opinions and participating in meetings.</p> <p>The CHC makes special efforts to cultivate leaders from culturally diverse backgrounds.</p> <p>The CHC is sensitive to diverse religious and cultural holidays, customs, recreational and food preferences.</p> <p>The CHC building is accessible to people with disabilities.</p> <p>CHC facilities are socially and culturally accessible to the community it serves.</p> <p>Structures and processes encourage participation by all stakeholders.</p> <p>Board members are representative of the make-up of the neighbourhood/population served by the CHC.</p>
<b>Opportunities for and Importance of Participation</b>	<p>Input by clients and community members is a part of key organizational decision-making processes, such as decisions on what services to offer.</p> <p>Participation by clients and community members has been incorporated into the CHCs vision and value statements.</p> <p>Staff, volunteers, clients and the community are involved in identifying issues and opportunities for the CHC.</p> <p>The CHC recognizes the contribution of clients and community members to the organization.</p> <p>Staff is supportive of participation by clients and community members.</p> <p>The CHC leadership supports participation by clients and community members.</p> <p>CHC staff is supported to attend staff development programs about citizen participation.</p> <p>CHC volunteers are supported to attend volunteer</p>

<b>Organizational Capacity</b>	
<b>Factor</b>	<b>Survey Questions</b>
	<p>development programs about citizen participation.</p> <p>The CHC uses its volunteers as a source of knowledge about its community and the clients it serves.</p> <p>The CHC makes it easy for me to participate in decisions about community health and social issues.</p>
<b>Attitudes Towards Participation</b>	How would you like to participate in the CHC? (developing policies, planning services/programs, implementing services/programs, evaluating services/programs, health advocacy group, public meetings, joint communications, annual general meeting, communications development/distribution, board member, community health issues).
<b>Participation</b>	(From Demographics information) I participate in the CHC in the following ways (board member, volunteer giving services/information directly to clients, volunteer in administrative role, committee member, client).
<b>Volunteer Activity</b>	(Questions under Community Capacity and ‘Volunteer Activity’)
<b>Sense of Control</b>	(Questions under Community Capacity and ‘Sense of Control’)
<b>Internal Structures and Processes</b>	<p>The CHC has clearly identified the structures and processes for involving clients and community members.</p> <p>The CHC hours of service meet the needs of the community.</p> <p>Participation by clients and community members is on-going through established structures and processes.</p> <p>Participation by clients and community members is issue driven.</p>

<b>Outcomes</b>	
<b>Factor</b>	<b>Survey Questions</b>
<b>Sense of Ownership</b>	My participation in the Centre has caused me to take greater ownership of community health issues.

<b>Outcomes</b>	
<b>Factor</b>	<b>Survey Questions</b>
<b>Life Changes</b>	As a result of work at the CHC, I have made important changes in my personal life.
<b>Enhanced Participation</b>	<p>Participating in CHC decision-making has made clients and community members feel more capable of being involved.</p> <p>All segments of the community are represented in decision-making.</p> <p>How has the number of volunteers changed since you have been with the CHC?</p>
<b>Community Cohesiveness</b>	<p>The CHC has changed its community's attitudes towards specific health issues.</p> <p>The activities of the CHC have led to a greater level of trust among community members/agencies.</p> <p>My experience at the CHC encourages me to be an ambassador for the CHC in the community.</p> <p>The CHC has increased the community's awareness of its strengths and weaknesses.</p> <p>Board members have shared their skills and knowledge about being a member of a community board with other groups in the community.</p> <p>The CHC builds shared values across the community.</p>
<b>Improved programs and/or services</b>	<p>The CHC is responsive to the needs of the community.</p> <p>The CHC offers a range of programs and services that meet the needs of the individuals and the community.</p> <p>Participation by clients and community members in CHC decision-making has led to improved access to its services.</p> <p>Participation by clients and community members in CHC decision-making has led to improved quality of its services.</p>